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UNIVERSITY OF ALBERTA

THE ROLE OF COMPLIANCE IN THE SEXUAL ABUSE AND ASSAULT OF DISABLED INDIVIDUALS

by

© SHEILA LYNN DONCASTER

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE DEGREE OF MASTER OF EDUCATION
IN
SPECIAL EDUCATION (SEVERE DISABILITIES)

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL 1991

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ISBN 0-315-70023-8

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Degree: Master of Education

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Date: July 25, 1991

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

THE UNDERSIGNED CERTIFY THEY HAVE READ, AND RECOMMEND TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH FOR ACCEPTANCE, A THESIS ENTITLED THE ROLE OF COMPLIANCE IN THE SEXUAL ABUSE AND ASSAULT OF DISABLED INDIVIDUALS SUBMITTED BY SHEILA L. DONCASTER IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION IN SEVERE DISABILITIES.

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Date 24 July 91

ABSTRACT

The purpose of this study was to explore the role of compliance in the sexual assault and abuse of individuals with disabilities. The conclusions and implications of the study are based on data included in victims' reports to the University of Alberta Sexual Assault and Disabilities Project. The current research analyzed 154 reports, the total available at the time of analysis.

The study specifically examined the prevalence of compliance and investigated the relationship of compliance to other important factors determining the nature and extent of assault.

The results of the study indicated that compliance was regarded as a risk factor in 23% of the reports. They also showed that overly compliant persons were significantly more likely

a. to be assaulted by nondisabled offenders

b. to be assaulted in group home or institutional settings

c. to be severely disabled, and

d. to find it difficult to acquire victim services following an assaultive incident

ACKNOWLEDGEMENTS

I would like to thank my thesis advisor, Dr. Dick Sobsey, for his support, patience, and encouragement as I struggled to complete this paper. Thank you to Dr. Linda McDonald not only for participating on my committee, but also for your ongoing interest and support. Thanks also to Dr. Eamonn Callan for being a member on my committee.

I would also like to acknowledge the Department of Health and Welfare Canada that contributed to the funding for the University of Alberta Sexual Assault and Disabilities Project from which I drew the data for my project.

Many thanks to my friends and family who maintained a constant belief in my ability to complete this program even when I did not. In particular, I would like to thank Steve Werk for encouraging me to enroll in the program, and for your constant support these last six years. Thanks to Jim Rickson for your generosity, to Doug Smith for your phone calls, and to Joyce Lewis for being the most understanding of co workers.

Finally I would like to acknowledge the contribution of those individuals that took the time and interest to respond to the surveys. For some of you the reliving of the incident in the retelling of it must have been extremely painful. The information you provided made this study possible. THANK YOU ALL !

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CHAPTER ONE

INTRODUCTION

This study explores the nature of sexual assault and abuse of individuals with disabilities. The conclusions and implications of the study are based on data included in victims' reports to the University of Alberta Sexual Abuse and Disability Project funded by Health and Welfare Canada as part of a national initiative against child sexual abuse. This survey collected reports of abuse and assault of both children and adults. The current research analyzed 154 consecutively received reports, the total available at the time of analysis.

PURPOSE OF THE STUDY

The purpose of this study was to examine if victims' tendency toward compliance influenced their vulnerability to assault or abuse and to investigate the relationship of compliance to other aspects of the abuse or assault incident. If compliance proved to be an important factor in determining the nature and extent of assault, implications for education and prevention could then be proposed.

In the following sections, the background of the study is presented, with a focus on the incidence of, influences on, and the general nature of the problem. A detailed description of the rationale, research questions, and the limitations of the study follow.

BACKGROUND TO THE STUDY

Sexual abuse of children and sexual assault of adults have become a growing concern in today's society. Children and adults with disabilities have not escaped the influence of this trend. In fact, there is evidence to support the conclusion that there is a higher incidence of abuse and assault in this segment of the population (Browning & Boatman, 1977; Chamberlain, Rauh, Passer, McGrath, & Burket, 1984; Davies, 1977; Diamond & Jaudes,1983; Shah, Holloway, & Valkil, 1982).

Incidence

Although it is possible to demonstrate that the incidence of sexual abuse and assault is higher for persons with disabilities, there is still a question concerning the actual number of victims. Sexual assault centres are reporting a substantial increase in service requests in the last few years, but they too are unable to ascertain the precise figures as so many cases remain unknown to even these experts. FBI statistics indicate that only 20% of all adult rape cases, whether the victims are disabled or nondisabled, are ever reported (Ryerson, 1981). Furthermore, the disabilities of victims are not included in standard crime reports or crime statistics in Canada or the United States.

When one attempts to assess the prevalence of assault among persons with disabilities, a number of factors tend to make it even more difficult to correctly establish accurate figures. Fewer incidents of assault may be reported by persons who experience communication deficits or intellectual impairments that interfere

with their ability to make articulate statements about their situations. Also, victims with disabilities may be assaulted by relatives, friends, acquaintances, or caregivers at an even higher rate than the general population, and it may be to the advantage of those that typically speak for the victims to remain silent. In 1981, the Seattle Rape Relief Clinic reported that in 99% of all sexual assault cases involving disabled victims the victim knew the offender (Seattle Rape Relief, 1981). In the general population, the same estimate is typically set at 65-85% (Cole, 1986).

In addition, in many cases of assault, the disability status of the victim is not a part of the information provided when a report is filed; therefore, victims with disabilities may never be acknowledged in the statistics. Finally, many victims with disabilities may fear the withdrawal of essential services and thus refuse to make their circumstances known. Considering these difficulties, it can be concluded that the problem is much greater than suggested by crime reports, statistics, or the literature.

Perspectives on the Phenomenon

Researchers have looked at the sexual abuse and assault of people with disabilities from many perspectives. It is important to assess the different approaches to the problem in order to develop a broader understanding of its nature.

One study (Sobsey & Varnhagen, 1989) proposes that it is not the person's disability that is the most significant influence on vulnerability to assault or abuse, but rather, it is society's treatment of that disability. The prevailing myths that surround individuals who have a disability are not particularly benevolent; in

fact, for the most part, they have been demoralizing and hurtful. In the literature review, these myths will be discussed with regard to the influence they have had on educational, legal, vocational, medical, and social programs.

Crossmaker (1986) presents a model for assault prevention. She proposes that the individual with a mental impairment is assaulted or abused for the same reasons that other high risk populations (e.g., children, adult women, racial minorities, and those labelled as mentally ill) are victimized. Isolation, lack of information, dependency, and powerlessness are the factors she cites as contributing to high rates of abuse and assault in these groups. She also indicates that if prevention programs are to be effective it is necessary to enact a comprehensive system change. A more detailed description of this model follows.

Crossmaker's Theory

A review of Crossmaker's theory will be presented in order to establish a more precise picture of the factors that perpetuate the sexual victimization of children and adults with disabilities. She has established four primary categories within her model, including, isolation, dependency, lack of information, and powerlessness. All the risk factors cited in the current research can be placed within the boundaries of these categories. While Crossmaker's model will not be the only one considered, it does offer valuable insight into the general phenomenon of assault and its origins.

Isolation

Isolation is one significant risk factor leading to increased rates of abuse and assault of persons with disabilities. In the past,

the medical profession's immediate response to the birth of a baby with disabilities was generally that he or she be institutionalized, a recommendation often disguised as something that was "for its own good" or for the good of the family. In this fashion, society's response to the infant's disability increased the likelihood that a child with a disability would live outside the home. However, the practice of "protecting" or "helping" people with disabilities by isolating them in institutional or other caregiving situations has only made them more vulnerable to assault and abuse (Finkelhor, 1980; Gochos, 1982; Musick, 1984). One study (Rindfleisch & Rabb, 1984) found that incidents of abuse and assault doubled for individuals with disabilities living in institutional settings.

A number of conditions are created when a person lives in an isolated situation, conditions that are potentially threatening to an individual's safety and autonomy. Through institutionalization, personal care functions of the most intimate nature are often being performed by a large number of paid individuals. Regardless of the efforts to ensure that the client and attendant are of the same sex, offences still occur as offenders are not necessarily of the opposite sex. The risk of assault or abuse may be increased with each additional caregiver in spite of all efforts to safeguard against it..

Another common practice, that of clustering assaultive individuals with defenceless victims in the same institution, further increases the risk of assault or abuse (Musick, 1984). The obvious solution to this situation is to separate these two populations, but as larger institutions are only financially viable

when they are more or less full to capacity, this creates a scenario where residents may be inappropriately placed.

Isolation in institutional or even group home settings often facilitates further the vulnerability of persons with disabilities by placing them in situations where they are socialized to comply with the requests of many authority figures. One recent case gives a distinct demonstration of the abuse that can follow from compliance.

On July 18, 1990, the leading Catholic church official in Newfoundland was forced to offer his resignation when faced with the findings of a commission that studied reports of the sexual abuse of boys by Catholic priests and lay personnel (Archbishop resigns, 1990). In many of the cases under review, the young male victims were residents of a Catholic orphanage.

Even more disturbing than the revelation that the priests were guilty of sexually abusing those who trusted and respected them is the fact that the first reports of abuse came to light in 1975 and were not fully addressed until 1990. This disclosure reveals the extent of denial and deliberate suppression of the truth regarding the phenomenon of sexual victimization, since for 15 years no action was taken to expose or punish the abuse even though complaints had been made on behalf of the victims. Although this example does not involve victims with disabilities, these victims were children in institutional care and therefore their vulnerability was increased just as are persons with disabilities who live in similar institutions.

In Montreal in 1986, 250 counts of abuse were brought against residential staff working in a Montreal group home (VanDusen, 1987). Unfortunately, the charges against the offenders were dropped since the victims were residents with mental disabilities and considered poor witnesses.

Abusive relationships are always unequal relationship. The perpetrator holds power over the victim, a relationship that is similar to the power staff in residential settings have over the residents. The extreme power inequity between staff in residential settings and the residents creates great potential for abuse (Musick,1984). The vulnerability of some victims with disabilities, as they strive to please those in authority, may be further complicated by these victims' frequent inability to differentiate between appropriate requests and inappropriate sexual victimization (Kelley, 1986; Ryerson, 1984). Many individuals with intellectual impairments simply comply with all requests.

This tendency toward generalized compliance, however, may not be inherent. For many years, special educators have been teaching compliance and generalization to students with disabilities in order to increase learning responses. Inadvertently, they may also have been making their students more vulnerable to inappropriate sexual advances and other forms of abuse and exploitation. Furthermore, the situations in which many individuals with disabilites live give rise to increased compliant behavior and need to be considered as a possible cause of the behavior. In the following section, lack of information, another key problem, will be discussed.

To this point, this chapter has only addressed the problem of isolation within institutional settings. In family settings, both children with handicaps and their families may experience isolation. Research suggests that this sense of isolation is a stress factor that contributes to the rate of abuse within the family regardless of the disability status of the child. (Brookhouser, 1987; Meier, 1978; Solomans, 1979).

Isolation, in conjunction with dependency, has one further effect on individuals with disabilities: Potential victims may have learned to view themselves as helpless and unable to affect their circumstances (Floor & Rosen, 1975). Perhaps the person has been unable to control any aspect of his or her life (e.g., what food they eat, what clothes they wear, or the person they room with). The potential victim may have learned that they have little autonomy in their lives, and as a result, they naturally fail to believe they have autonomy in the area of sexual encounters. This characteristic is referred to as "learned helplessness," and it further increases the possibility of assault or abuse (Kelly, 1986).

The influences just outlined may prevail in situations where individuals with or without disabilities are isolated from the general population. Reports in current research cite isolated living arrangements, trust, compliance, and approval seeking behavior as risk factors that make people with disabilities more vulnerable to assault.

Lack of Knowledge and Understanding

According to Crossmaker's model (1986), another factor that contributes to the assault of children and adults with disabilities is

the misguided practice of refusing to offer them adequate and appropriate information regarding sexuality, assault, and assault prevention measures. It has been historically assumed that educators, parents, and so forth either cannot or should not educate individuals with disabilities as to the proper expression of their sexuality. This assumption has disregarded the fact that it is impossible for any person to make responsible decisions without adequate information. The old adage that "what they don't know won't hurt them" simply does not hold true. Research shows that it is both possible and necessary to offer adequate information and training (Bergman,1984; Hamre-Nietupski & Ford, 1981; Ryerson, 1981; Ryerson & Sundem, 1981). Failure to do so is highly irresponsible and potentially dangerous to people with disabilities.

When it is realized that the child without handicaps often learns proper sexual-social behavior by observing family role models, it becomes even more evident that people with disabilities must be offered education. It is especially important for those individuals living in environments where these models are not available and where inappropriate sexual behavior is more often the only behavior that can be observed.

In this study lack of knowledge and judgement is the most common risk factor identified, while compliance is a close second.

Dependency

The third risk factor Crossmaker identifies is the high degree of dependency experienced by the individual with disabilities in our society. Any impairment, whether it is physical, communicative, intellectual, psychological, or sensory, can in itself make an

individual with a disability more dependent. As a result of a disability, a person may require physical assistance, social-emotional support, psychological approval, protection, and economic support. Lack of appropriate public information about disabling conditions can also lead to misunderstandings regarding the capacity of a person with a disability to govern their own lives (Aiello, 1984/1986). In the current study, physical defenselessness and communication deficits were commonly cited as risk factors.

Once again, the non-disabled community's response has played an important role in defining the nature of this dependency (Aiello, 1984/1986). Society has increased the disabled person's need for economic support and has lessened their sense of autonomy through inadequate employment opportunities, segregated and often inappropriate education, lack of appropriate public transportation, and, until recently, by the continued support of institutionalization.

Powerlessness

Perhaps the end result of these factors is the eventual sense of powerlessness that is experienced by potential victims. Although some of this sense of powerlessness can be attributed to the victim's disability or disabilities, it is necessary to recognize that factors beyond the victim's disability are also playing important roles (Musick, 1984). Crossmaker asserts that one of the fundamental contributions that can be made by our prevention and education programs is the empowerment of people with disabilities. At present, the hope that people with disabilities may experience autonomy or the right to make choices and learn from their mistakes is only a vague possibility.

Other Theories

While Crossmaker has proposed one theoretical framework from which to evaluate the matter of sexual assault, over the years, other sociological models have also been proposed. A number of these models are discussed in an article by Zirpoli, Snell, and Loyd (1987). One early model, presented by Miller in 1959, referred to as a psychiatric model, focuses specifically on the characteristics of the offender as the primary cause of assault. It is now a model that is rarely supported as the incidence of abuse by those who are mentally ill is estimated to be only 10%.

Another model considers the family, community, and cultural values and suggests that abuse is primarily caused by individual and family stress (Sobsey, 1990). The social-situational theory directs attention toward the interactions between the parent and their child and includes the role of the victim.

A final model is based upon Bronfenbrenner's (1977) ecological model of human development and proposes, like Crossmaker (1986), Doe (1990), and Sobsey (in press), that child abuse is determined by a multitude of factors. The variables include the characteristics of the individual, the family, the community, and the socio-cultural environment (Belsky, 1980).

While the preceding authors have been responsible for establishing the broader models or perspectives on sexual assault and abuse, others have researched more specific aspects of the phenomenon. Researchers have considered the influence of particular disabilities and their severity (Zirpoli, Snell, & Loyd, 1987). They have also evaluated the contexts found in families

reporting assault, for example, the marital quality of families with a child with a disability. They have investigated the personality types and characteristics of offenders (Finkelhor, 1984). Others have evaluated and proposed legal modifications and educational and prevention programs (Crossmaker, 1986), and they have looked at the influence of abuse on incidence of disability (Brandwein, 1973; Rose & Hardman, 1981).

As a result of research currently being conducted, a number of more specific questions are surfacing:

a. What is the incidence of assault in the disabled population, and is the incidence higher than in the nondisabled population?
b. What factors put people with disabilities at risk for abuse and assault?
c. What prevention and victim services are available for the person with disabilities, and do they meet their needs?
d. What is the relationship of the victim with disabilities to the offender?
e. What are the physical, emotional, and/or the social effects of sexual assault and abuse?
f. Is the victim's disability a result of the abuse rather than a potential cause of it?

THE RATIONALE

As an instructor in the field of special education and rehabilitation, I have, over the last 14 years, taught many students

or clients who have been physically, sexually, or emotionally abused; and I recognize the tenuous position of all my students with regards to any form of victimization. The personal reasons for pursuing this line of research originates out of an interest to establish an expertise in an area that I perceive as important to the students I teach.

Concern and confusion often exist in the minds of administrators, caregivers, and parents regarding sex education and assertiveness skill training. With current and reliable information, I envision that I may better reassure and encourage them to question past practices and open up to the possibility of instruction in these areas. It is my contention that skills in assertiveness and proper expression of sexuality will serve to increase the quality of life of my students and reduce their vulnerability to abuse.

On a less personal level, I recognize the responsibility of special educators in the reform of current programs and in the creation of new initiatives. It is my hope that the current research will help to provide a better understanding of the nature of the problem in Canada and of the prevention strategies that could be taught by educators.

My research could have assessed many aspects of the data, but given the concerns I have outlined, I chose to isolate compliance as a risk factor and to evaluate its importance. Should compliance be significant in determining the incidence and nature of assault, then implications for assertiveness training could be drawn.

RESEARCH QUESTIONS

1. Does a disabled assault victim's proclivity toward compliance influence their vulnerability to abuse ?

2. Is the nature of an abusive incident significantly different in cases where compliance is identified as a contributing risk factor as opposed to cases where this factor is not reported?

   a. Is there a significant relationship between the severity of disability of the victims and compliance?

   b. Is there a significant relationship between the propensity of a victim toward compliance and the disability status of the offender?

   c. Does a significant relationship exist between the victim's compliance and the location of the assault?

   d. Is the presence of compliance significantly related to the extent and type of services provided after an incident of assault?

SUMMARY OF THE CHAPTER

As the background information suggests, the nature and causes of assault are varied and create complex issues needing further clarification and investigation. Crossmaker has proposed one model with which to evaluate the nature and effects of assault on victims who are disabled. This could be called a generic model because it can also be applied to nondisabled victims in our society. Throughout the current research, this model will be referred to as the data are presented and discussed and will be reviewed when prevention strategies are proposed in Chapter 5.

As the findings of the current research unfold, it will be possible to see how multidimensional the issue of assault of persons with disabilities truly is and how disturbing. The results and implications of this study may not greatly surprise the insightful and experienced professional who works with people with disabilities; however, as is often the case, insight rarely leads to action until a certain level of awareness is reached. Perhaps this study will help raise that level slightly higher and offer practical information that can actually be of use.

It is hoped that with continued exposure to the facts society will finally begin to afford adequate protection for the rights and freedoms of people with disabilities and create a society where they feel both safe and empowered. However, before presenting the results of the current study the following section will review some of the previous literature written on this topic.

CHAPTER 2

REVIEW OF THE LITERATURE

A review of the existing literature identified terms and definitions, the general nature of assault and abuse of people with disabilities, its incidence, and the rate of reporting. Also, studies were evaluated that present the risk factors for individuals with disabilities and include the following:

a. offender characteristics,
b. the role of compliance,
c. the role of learned helplessness,
d. risks associated with particular disabilities (e.g., impaired communication, physical disability, intellectual handicaps),
e. specific risks relating to child abuse,
f. severity of a disability as it relates to incidence of abuse,
g. society's response to a disability as it affects the nature and extent of abuse, and
h. lack of knowledge and judgement on the part of the victim.

Finally, material concerning the prevention of sexual assault and abuse was examined and includes the following: suggested legal and administrative reforms, the need to alter societal attitudes toward a person with a disability, and the role of education, for

example, sex education programs, sexual assault prevention programs, legal services, assertiveness training, communication training, and discrimination training.

DEFINITIONS

Before studying the literature that discusses the issues surrounding sexual abuse and assault, the terms must first be defined. Authors and researchers alike differ in their definitions of sexual abuse and sexual assault, and it is necessary to determine what definition has been used in a particular study or paper. One author may consider obscene remarks as an act of abuse, while another may not. One article suggests that whether a sexual act is abusive or assaultive or not should be judged according to the effect that it has on the victim rather than the nature of the act itself (Sobsey & Varnhagen, 1989). Of course, the effect of abuse or assault may be very difficult to measure as the victim may be extremely careful to hide the resulting effects so as not to suffer further repercussions (i.e., loss of services, removal from the family). Cole (1986) suggests that sexual abuse can include visual, physical, or verbal acts of aggression that can be judged as unwanted sexual activity, especially if the victim is less than the age of consent.

Sexual Exploitation (Rape, Incest, Indecent Liberty)

Ryerson (1981) defines sexual exploitation in the following way: legally, sexual exploitation refers to rape, incest, and indecent liberty, commonly known as child molestation. Sexual assault is any form of unwanted sexual contact between adults when the offender

uses physical force or when the victim does not consent to the act. Compliance as a personality characteristic would more likely lead an individual to yield to the wishes of another even against their better judgement. Forced intercourse includes anal, oral, or vaginal penetration with a penis or an object. Incest refers to sexual acts between unmarried family members. Indecent liberty, which is sometimes referred to as child molestation, is sexual fondling of the private body area but does not include sexual intercourse. Sexual abuse refers to any form of sexual contact between a child and an adult where the victim is 12 years of age or less.

In reality, much more than physical violation is involved in sexual assault and abuse. The individual that is violated suffers immediate and long-term emotional effects (e.g., shame and guilt) and social repercussions (e.g., withdrawal). In many cases, that damage is irreparable and more serious than the physical act of abuse itself (Cole, 1986). Cole points out that a child who receives no physical contact can suffer from a deprivation equally as damaging as those that are abused or molested, and this deprivation may make them more open to violation. Similarly, abuse may also be defined as an act of omission, that is, when the dependent adult or senior is denied sexual expression of any type (Fifield, 1986).

Informed Consent

The term informed consent originated as a result of a series of judicial interpretations in contract and criminal law. Ames, Hepner, Kaeser, and Pedler (1986) define consent as having three separate elements: (1) having the capacity, that is, having the ability to acquire knowledge and become informed; (2) being informed, that is,

the ability to understand the advantages and disadvantages associated with the decision facing them and to choose a course of action accordingly; and (3) being voluntary, that is, the absence of force during the decision-making process.

People can be deemed incapable of informed consent if they cannot talk, cannot physically resist, or have a mental disability that prevents them from understanding sexual intercourse or its possible consequences. A person who has sexual intercourse with a disabled individual may be charged with sexual assault under the law if the province or state has included this clause in the sexual assault statute. The opposite may also occur when a disabled person with poor communication skills is judged as consenting to a sexual interaction when in fact they are simply unable to resist or say no clearly. The current study defines sexual abuse as all sexual acts with children (12-years-old or younger) and sexual assault as sexual acts against adults without consent. The reports of abuse collected in the current research include all of the violations described.

OVERVIEW OF THE PROBLEM

As was described in the introduction, the matter of sexual abuse and assault is complicated. The phenomenon has its origins deeply rooted in our history, and it is bound to the values of our society. Although violence is by no means a recent social concern, as our society begins to tackle the issue more intentionally, our generation has more information with which to assess the nature of the problem. As research more firmly establishes the incidence of sexual abuse and assault, it also gives more accurate information

regarding its general nature. The following section will summarize some of these findings.

It was once felt that abuse and assault most often occurred at the hands of a stranger. The recent statistics suggest that this is definitely not the case. In approximately 75% of the cases of abuse in the general public, the abuser is a friend or relative of the victim (Brookhouser, Sullivan, Scanlan, & Garbarino, 1986). Cole (1984) put her estimate at 80%, while the Seattle Rape Relief Clinic (1981) estimates that in cases of abuse and assault against a victim with a disability this figure could rise as high as 99%. The current study also found that the offender was rarely a stranger to the victim.

Similarly, Jaudes and Diamond (1985) determined that sexual offenders are generally related to or at least well-known to their victims. They also conclude that the disabilities of the victims were not the only nor the most influential risk factors. They suggest that other factors must also be considered:

a. the offender's power and relationship to the victim,
b. how society's response to a disability may influence the possibility of abuse,
c. the lack of prevention services, legal services, sex education, and victim services offered to the person with disabilities, and
d. the role and responsibility of our society in reducing and preventing cases of assault and abuse.

An overview of some of the findings from the nation-wide study being discussed in this thesis were reported in *The Edmonton Journal* (Mullen, 1988):

a. a person with disabilities is about 1.5 times as likely to suffer from sexual assault as a person without disabilities,
b. a significant number of caregivers of persons with disabilities have been previously convicted of sexual offence,
c. the law prevents the testimony of a developmentally delayed person even though it allows the testimony of a child who may have similar intellectual capacities,
d. when an offence is reported, the law may not lay charges as they consider the victims inadequate witnesses, and
e. often the victims do not file a report as they are afraid they may lose essential services and be returned to an institution.

These results outline some of the difficulties facing the sexually abused person with disabilities. Not only are they more likely to be victimized, but also, they are in the unfortunate position of having less legal recourse and support should they be abused or assaulted. They are likely to be abused by caregivers, and they may feel a great deal of pressure not to report if the abuser is a caregiver.

On a more hopeful note, the article by Mullen (1988) as well as others (e.g., Flavelle, 1990; Lee, 1991) have appeared in major Canadian newspapers; and as a result of this type of coverage, a more informed public may be emerging. Better media coverage can act as a catalyst for improvements in current conditions and help to diminish the effects of long-standing myths.

The Myths About the Disabled in our Society and Abuse and Assault

For centuries, the individual with disabilities has suffered from inaccurate assumptions and hurtful myths, including some that have had significant influence on the nature and extent of sexual abuse (Sobsey & Mansell, 1990). In a very insightful article by Cole (1986), a summary of these assumptions and myths is presented. She describes how for years society has refused to regard persons with disabilities as potential victims of abuse or assault. It was assumed that no one would take advantage of society's most defenceless. As a result no one believed that the abuse was occurring, and thus, appropriate legal and prevention services were not created. This problem is compounded because it was believed that it is not really a crime to assault someone who is different and who lacks both power and dignity.

Another common misperception occurs when persons with disabilities are viewed as asexual, that is, not eligible for assault or unable to participate in sexual behavior. The influence of this assumption manifests itself in a lack of proper sex education and assault prevention programs. Further difficulties arise when individuals with disabilities are not viewed as adults and their

abilities and rights are seriously questioned. Table 1 outlines these myths and their potential effects.

Table 1

Myths and Effect

Myth	Effect
No one would assault a defenceless person with disabilities.	Disbelief of a report of abuse or assault.
A person with a disability is asexual.	Belief that a person with disabilities is not eligible for assault or sexual behavior.
	Sex education and assault prevention programs are deemed unnecessary.
	Unnecessary questioning of and pressure on the victim.
That offenders are strangers to the victim.	Lack of protection within group homes and institutions
Someone who cannot speak would not understand what happened anyway.	An abusive act is justified.
	Rights are not acknowledged.
Persons with disabilities lie about assault.	Lack of convictions and legal support.
Persons with disabilities are promiscuous, asking for what they get.	Offenders find it easier to commit an act of assault with less fear of conviction.

Persons with disabilities are not adults and therefore not credible witnesses.

The disabled victim is "different."

Cases of sexual abuse are not viewed as serious crimes.

Today, service providers, parents, and educators who live or work with individuals with disabilities are attempting to create an accurate picture of the hazards facing their clients, children, or students and to discover strategies that will prevent abuse and assault. Others are looking for the best possible means to assist victims of assault to experience a sense of surviving the assaultive incident and to move on with their lives.

STUDIES MEASURING INCIDENCE

Chapter 1 briefly touched on the topic of the incidence of sexual assault. It will be considered in more depth in this section of the paper. Recently, research on abuse and assault has been aimed at establishing the magnitude of the problem. Incidence has been measured in a number of different ways, and while some measures may be more reliable than others, there is a general consensus that it is a problem that does not lend itself readily to accurate measurement. Given this qualification, the following findings have been uncovered. The incidence of sexual abuse in our society is presumed to be much greater than once thought. Badgley (1984) estimates that 1 in 2 girls and 1 in 3 boys had been victims of sexual offences. According to a United Way study completed in the same year, 1 in 4 Canadian girls and 1 in 10 boys are likely to be

sexually assaulted before the age of 18. The discrepancy of estimates can be seen in these two examples.

Studies assessing the prevalence of sexual abuse and assault among persons with disabilities are establishing a somewhat clearer picture of the problem, but as mentioned earlier in the introduction, the actual figures are difficult to establish for a number of reasons. Many cases are never reported (Ryerson, 1981), and it is estimated that only 1 in 5 cases are identified to the authorities. Also, if a report is filed, the presence of a disability is not part of the required information. In many cases, if sexual abuse is accompanied by physical battering, it is difficult to determine if the disability was present before the abuse occurred or if it arose as a result of it. Frodi (1981) also notes that many abused children seemed to have developed some behavior patterns in response to abuse (e.g., inhibition of gross motor activity and language), and they may in fact function at a lower developmental level, increasing the perception of their disability. Finally, survivor services frequently have not been made available to persons with disabilities; thus, documenting the incidence of abuse and assault using these sources is not a reliable measure.

Brookhouser, Sullivan, Scanlan, and Garbarino (1986) suggest several reasons why children hesitate or refuse to report abuse:

a. feelings of shame and guilt,

b. fears of threats from abusers,

c. fear of institutional and/or family punishment (i.e., the father may be jailed, or they [the victim] could be placed in a foster home,
d. the child feels he or she will not be believed, and
e. due to limited knowledge, they do not know what abuse is.

Cole (1986) suggests several other reasons why persons with disabilities might not report an abusive incident:

a. fears of abandonment,
b. fear of further victimization,
c. a belief that they deserve punishment,
d. the belief that authority needs to be obeyed,
e. fear that if they reported they would destroy the home, and
f. feelings of shame that manifests as feelings of no worth to self or society.

In order to arrive at any estimates of the abuse and assault of people with disabilities, researchers have used three different methods of data collection. Some studies have taken wide-scale samples of abuse and assault victims and have calculated the representation of the different disabilities in the samples. After determining the representation, the studies then reveal if disabled people were over- or under-represented in the samples. Shah et al. (1982) studied reports of abuse of 174 patients admitted to the Toronto Hospital for Sick Children. In four percent of the cases, the

children were disabled. Andre (1985) found that of the children served by social service agencies 25% of the handicapped children had been maltreated as compared to 16% among the nonhandicapped children. Davies (1979) found that child incest survivors were three to four times more likely to have abnormal EEG readings and epilepsy. Cholier and Lehr (1976) reported on a Parents Anonymous study that showed that 58% of the members' abused children had developmental disabilities prior to abuse and on the Denver Department of Welfare study that indicates that 70% of abused children exhibited mental or physical "deviations" prior to their abuse. The Advocacy Resource centre of Canada suggests that persons with disabilities are twice as likely to be sexually assaulted as persons without disabilities.

Other studies, (Boyle, Rioux, Ticoll and Felske, 1988; Brookhouser, et al., 1986; Chamberlain, et al.,1984; Jaudes & Diamond, 1985; and Jones, Shelan, and Buckman, 1980) have taken wide-scale samples of people with disabilities and measured the prevalence of abuse and assault within the group. Through comparison, these studies evaluated whether the incidence rate for persons with disabilities was higher or lower than in the general population. In a study of 164 cases of children with cerebral palsy, 14% of the patients had a history of abuse (Jaudres & Diamond, 1985). Of 87 adolescent and young adult girls with mental impairments referred for birth control, a history of abuse was reported in 25% of the cases (Chamberlain et al., 1984). Otalaryngological examinations of 55 children with multiple disabilities and hearing impairments revealed that 96% of them had

been sexually abused (Brookhouser et al., 1986). Jones, et al.,(1980) estimate that the risk of physical and sexual abuse was three to ten times greater for children with disabilities. A national forum on women and disabilities conservatively estimated that 39% to 68% of girls with disabilities would be sexually abused before the age of 18 (Boyle, et al., 1988).

In a third measure of abuse and assault, researchers questioned staff in service agencies for victims of assault. In one study, it was assessed that the majority of child protection workers believed disabled children were at greater risk for abuse (Schilling, Kirkham, & Schinke, 1986) In a nation-wide study distributed to 90 Canadian Sexual Assault Centres, all respondents acknowledged a higher risk of assault and abuse for people with disabilities (Sobsey &Varnhagen, 1989).

However, it is difficult, with underreporting being so high, to use any of the measurement approaches with absolute reliability. It has been suggested that there is a a strong connection between factors contributing to abuse going unreported by victims and factors that contributed to those victims' vulnerability to abuse.

STUDIES EVALUATING RISK FACTORS

The risk factors that influence an individual's vulnerability to assault are not easily determined. What may prove to be a problem for one victim may not be involved in the assault of another. Although a number of possible influences have been identified in the current research, any number of these factors may interact so as to increase the risk of vulnerability

Offender Characteristics

In evaluating the risk factors involved in the abuse of individuals with disabilities, it is valuable to consider the offenders, their personal characteristics, and the role they play in the lives of the victims. A large percentage of the perpetrators of sexual abuse are men, and the victims have been reported to be either a mixed group or primarily female (Finkelhor, 1984). Generally, men who commit the offences are looking for individuals that can be easily coerced or forced into submission. As individuals with disabilities are often taught to be compliant, they may be viewed as easy targets (Sobsey & Varnhagen, 1989).

As cited earlier, the offenders in cases of abuse and assault committed against people with disabilities are generally individuals in positions of trust (e.g., relatives, caregivers, teachers, transportation providers). As has been indicated in a number of studies (Brookhouser, Sullivan, Scanlan, & Garbarino, 1986; Shah, Holloway, & Valkil, 1982; Sobsey, 1989), it is this common characteristic of familiarity and contact between the victim and the offender that increases vulnerability. In the general population, the victim knows the offender in approximately 65-85% of abuse cases; and according to a Seattle Rape Relief Center study, (Seattle Rape Relief Developmental Disabilities Project, N.D.) victims with disabilities know their offender in 99% of the cases. The age-old practice of being on guard for abuse from strangers is not a particularly helpful practice, and given these statistics, the implications for prevention shift toward safeguards within the home and in familiar settings.

A closer look at the personality of offenders reveals that certain traits are more prevalent in particular groups of abusive individuals. In cases of incest, it was found that there was often a high rate of depression in the mothers and alcoholism in the fathers (Browning & Boatman, 1977). In a study by Andre (1985), parents that maltreated children with handicaps were often substance abusers and/or suffered from emotional problems. Other studies suggest that often parents that sexually abuse their children were sexually abused themselves as children (Fagan & Wexler, 1988; Finkelhor, 1984; Langevin, Wright, & Handy, 1989).

Compliance Studies

A study by Ryerson (1984) evaluated data from 700 assault cases collected over a 7 year period in the Seattle-King county area. The author identifies a number of risk factors. An association was made between the victims lack of knowledge, their high rate of compliance, and the low rate of reporting. Not only had the victims never been taught the inappropriateness of the offences, but also, the offenders were frequently authority figures to whom the victims had been taught to comply.

In fact, special educators have been concerned with teaching their students to be more compliant and to generalize this co-operation across a number of teachers. One study notes how the cumulative index for the last 20 years of the Journal of Applied Behavior Analysis (1987) listed 80 articles on teaching generalization to persons with developmentally disabilities and only 4 on teaching discrimination (Sobsey, 1990). If disabled students are being taught to generalize compliance to the requests of a

number of trainers in teaching situations, they may also be generalizing compliance to less appropriate sexual advances outside the instructional setting.

Learned Helplessness-Overcompliance

The term learned helplessness was first coined in 1963 to describe the impaired performance of retarded children on a simple discrimination task following prolonged failure on unsolvable problems. Kelley (1986) considers learned helplessness as it relates to the sexual abuse of children. She first describes the most recent hypothesis on learned helplessness in humans as proposed by Abramson, Seligman, and Teasdale (1978). This hypothesis consists of four separate steps:

a. objective noncontingency: the child learns that attempts to avoid an abusive incident do not affect the eventual outcome;

b. perception of past and present noncontingency: the child experiences a feeling of helplessness due to his or her inability to affect the outcome in the past and, therefore, feels he or she will also be ineffective in the present;

c. attribution: the child attributes the cause of the abuse to his/herself; and

d. expectation of future noncontingency: the child will be abused over and over as he/she believes he or she cannot affect the future due to past experiences.

The self-blame experienced by the victims as described in step "c" is significant in the application of the learned helplessness theory. According to Bulman (1979), self-blame comes in two forms: characterological and behavioral. Behavioral self-blame relates to control and evaluates one's behavior as modifiable while believing in the future avoidability of a negative outcome. Characterological self-blame is associated with the belief that one deserved the past negative outcomes and as a result the victim will view themselves as helpless across many situations. The second form is important to the study of victims of child abuse. They will often be abused for years and often evaluate themselves as globally ineffective or helpless.

Abramson, et al. (1978) suggest that three deficits are produced as a result of learning that outcomes are uncontrollable. There is a motivational, cognitive, and emotional effect. The motivational deficit manifests itself in reduced incentive for initiating voluntary responses. Cognitive deficit may cause the individuals to believe more easily that responses and outcomes are contingently related. Finally, the emotional effect shows up as an experience of anxiety.

In a study that examined the phenomenon of helplessness and individuals with mental retardation, Floor and Rosen (1975) found that helplessness was a meaningful personality variable and that it could be measured objectively. However, the assumption that individuals who had been institutionalized were more likely to suffer from this phenomenon did not prove accurate. Retardation

itself seemed to be the more significant variable. Floor and Rosen (1975) suggest that the subjects in their study who lived at home were often denied decision-making opportunities to the same extent as those in institutional settings. They suggest that helplessness is compounded by low I.Q.s and a sheltered experience at home or within an institution.

In an article by Floor & Rosen (1975), it is suggested that learned helplessness might also prove to affect the outcome of integration efforts, and that I.Q. may not significantly relate to success in the community while personality factors are more important than intellectual level. It was also noted that there was a significant relationship between personal and social adjustment among community members with mental retardation. The ability of individuals with mental handicaps to express their sexuality appropriately and their ability to defend against assault could be considered community living skills and would be negatively affected by learned helplessness as described in the hypothesis presented.

In a study by Cullen and Boersma (1982), the authors studied learned helplessness and the effectiveness of training procedures for reversing the behavior. Thirty boys with learning disabilities and thirty normal achieving fourth grade boys participated in the study. Both groups experienced failure at a problem-solving task and were given self-instructional training, tutor assistance, or no training. Training effects were tested on a subsequent problem-solving task. The results of the study show that characteristics of learned helplessness were present in the boys with learning disabilities, while the normal achievers had developed successful

coping strategies. More relevant to this study was the finding that tutor instruction helped reduce learned helplessness for the students with learning disabilities. A similar instruction strategy might help the victims of assault be less vulnerable to exploitation, and it points directly toward the importance of prevention training.

The concept of learned helplessness is not interchangeable with the concept of compliance, but it is possible to consider how the two might influence each other and increase vulnerability. An individual who has learned that attempts to take control of his or her life only meet with failure might learn that compliance is the only alternative. Also, a person who has habitually complied to the requests of others might, in fact, experience a feeling of helplessness and anxiety and a lack of motivation to take on steps to control his or her destiny.

Disability Effects

Impaired Communication

Communication impairment has been identified in many cases of child abuse (Shaman, 1986). Impaired communication may make it impossible or difficult for both children and adults with handicaps to protest against assault, and it is even more unlikely that they will file a complaint against the offender. Other victims might have the capability of making a protest or verbalizing a complaint, but they rarely initiate conversations. As indicated in one study (Sobsey, 1990), many individuals with a mental handicap have been socialized into the role of responding, making it quite unusual for them to report an offence unless asked directly about it. In studies evaluating the communication skills of individuals with disabilities,

the results indicate that communication impairments affect both the number of interactions and the content of communication (Light, Collier, & Parnes, 1985; Orelove & Sobsey, 1987).

In the study by Ryerson (1984) cited earlier, the offenders were well aware of the difficulty their victims would have in filing a report; consequently, the victimization frequently continued for years. The study revealed that often the victimization began when the child was between two and five years of age and continued for five to 15 years (Ryerson, 1984). Unlike most nonhandicapped children, who learn to articulate their concerns more clearly as they grow older, abuse victims with communication impairments continue to have difficulties even as they mature, and thus, they are likely to suffer continued abuse.

Physical Disabilities

Individuals with physical handicaps often face two separate risks. The most obvious difficulty is their impaired ability to defend themselves physically. Second, they often depend on others for their personal care, requiring intimate exposure and contact and minimizing personal contact.

Maladaptive Behaviors

Children or adults who are abused often develop a number of behavior patterns that were not present prior to the abuse. Withdrawal, regression, and emotional reaction are just a few of the problems that have been cited (Sobsey, 1990). In a study by Parke & Collmer (1979), the authors indicate that a child's behavior pattern contributes to abuse and may elicit abuse. However, they also

suggest that abuse may cause children to develop behaviors that contribute further to abuse.

Severity of Disability

Are individuals with severe disabilities more at risk for abuse and assault then their less disabled peers? This might be assumed to be the case as an individual with severe or multiple disabilities may be:

a. less able to defend themselves,
b. unable to articulate the events surrounding abusive incidents,
c. more dependent upon and more controlled by the people providing care, and
d. more likely to live in an isolated environment.

In a study by Zirpoli, et al., (1987), the authors found that abuse increased for individuals who were classified as severely disabled. This study compared teacher ratings on level of functioning and rate of maladaptive behavior for 91 abuse victims to 91 randomly selected subjects. The results indicate that there is a significant relationship between abuse status and severe disabilities. It was also interesting to note that individuals with profound disabilities were less likely to suffer from abuse. The authors imply that these individuals might suffer less from assault because they have very few interactive skills and offenders prefer a victim that responded more to their attention even if it is in the form of resistance. In a second study by Sobsey (1990), the results of a survey of service agencies across Canada indicate that most

assault centres do not serve the needs of persons with severe disabilities. Given that they seem to be at greater risk for abuse and are most in need of counselling and education, this would seem to be a poor practice. Also, the lack of victim services might increase the risk of repeat incidents.

The data in the current study indicate that severity of disability relates significantly to compliance and that the more severely disabled victim is often more likely to be compliant.

Child Characteristics and Family Dynamics

Particular factors may be more important in the study of child sexual abuse than in the study of adult sexual assault, for example, it may be difficult to determine if a disability was present before the abuse occured or was a result of it. Prematurity and low birth weight are two other factors that have also been considered. Studies that have evaluated child abuse (e.g., Brookhouser et al., 1985; Finkelhor, 1986; Frodi, 1981; Shaman, 1986) have considered a number of separate issues:

a. particular child characteristics that may put that child more at risk,
b. the characteristics of abusing parents,
c. the incidence of abuse in the handicapped child population versus the nonhandicapped population, and
d. service provision for the child that is abused.

As a result of a study of incidence and prevalence of child sexual assault in Canada (Badgley, 1984), 52 recommendations were made regarding the need for social and legal reforms. New

initiatives in public policy to aid in the prevention of child sexual assault were clearly needed. The study found that one in two females and one in three males have been sexually abused. Four of every five victims have been abused before the age of 21 and that the majority of the cases go unreported. The study did not evaluate the incidence of abuse against children with handicaps, but the implications of the study would also apply to this specific population.

A study by Finkelhor (1986) shows that particular family dynamics place children more at risk of abuse including when

a. the child lived with only one of their biological parents,
b. the mother worked, was ill, or suffered from a disability that made her unavailable to the child,
c. the parent's marriage was in turmoil,
d. the child had an extremely difficult relationship with his or her parents, and/or
e. the child has a stepfather.

As identified in a study by (Shaman, 1986), there may be specific child characteristics that increase the possibility of abuse (i.e., children are dependent on adults, they obey authority). These characteristics are often attributed to disabled adults as well.

A study by Frodi (1981) evaluated the effects of characteristics of atypical (premature) children on the physiological and emotional responses of young parents and delineated characteristics of abusive parents. She also suggests that child and

abuser characteristics interact to create further difficulties. She notes that infants born with mental, physical, or behavioral abnormalities are often more at risk for abuse. However, as was described earlier, it may be difficult to determine if the abuse was the cause of the impairment or abnormality or the result of it. Excessive crying as perceived by the parent was identified as the trigger for abuse in 80% of early child abuse cases (i.e., where the child was less than one-year-old). The research demonstrates that the cry of a premature child tends to be more distressing than the cry of a full-term infant as a result of its variability and pitch. Two studies evaluated parental response to videotapes of children, premature and not, crying and smiling. The premature child triggered a response in the subjects consistent with aggression. Premature infants were chosen as this group of infants have high rates of abuse, and premature infants often have characteristics similar to other groups of disabled children (e.g., developmental retardation and unresponsiveness). A study by Brookhouser et al. (1985) also supports this finding. The research found that although low birth weight infants only comprised 10% of newborns they represented 20% to 25% of the physically abused population.

In a third study, Frodi (1981) measured the response patterns of 16 mothers with premature babies and 16 mothers with full-term infants. The results suggest that the mothers with premature infants had become sensitive to aversive features in their babies and had an exaggerated negative response to the stimulus babies used in the study.

In a final study by Frodi and Lamb (1980), 14 abusive mothers were matched with 14 nonabusive mothers, and the findings indicate that

a. when exposed to infant crying, both groups evidenced heart rate acceleration and increased diastolic pressure and skin conductance and that the arousal was greater among the abusers;
b. the abusers showed more annoyance and less sympathy than the nonabusers; and
c. it was difficult to distinguish between the abusers' reaction to smiling and their reaction to crying: the abusers responded as if any interaction were aversive.

The authors suggest that their results support the proposition made by Berkowitz (1974), who asserts that when an infant's features or behavior are viewed as aversive the child becomes aversive. Frodi and Lamb (1980) also suggest two contrary hypotheses: Parents who abuse may not be inherently different from non-abusers, but they develop an abnormal response pattern through interaction with their offspring; and conversely, children may not have aversive behaviors initially, but they learn the behaviors as a result of poor parenting. Perhaps a third supposition could be considered: The children's behavior is in fact normal, but the abusive parents characterize it as aversive.

In assessing the characteristics of abusive parents, Frodi and Lamb (1980) suggest that the parents may perceive their child as uncontrollable and have developed a sense of "learned helplessness"

in dealing with their crying. The authors note that studies employing the learned helplessness paradigm have determined a strong relationship between uncontrollable noise and aggressive behavior. Finally, the authors suggest that the marginally atypical infant may invite abuse from a parent by his/her inability to meet expectations and his/her difficulty in rewarding good parenting when it does occur.

A study by Andre (1985) compared maltreated children with handicaps with nonhandicapped maltreated children with regard to prevalence of maltreatment, differences in family characteristics, and the nature of services provided for the two groups. In the study, the sample consisted of approximately 300 maltreated children with handicaps, 300 non-maltreated children with handicaps, and a comparable number of children without handicaps from both the maltreated and the non-maltreated groups. The findings of the study reveal that the incidence of maltreatment among children with handicaps (25%) was higher than among all children served by public social service agencies (16%). Also, Andre found that there was a higher incidence of substance abuse and emotional problems among the caregivers of the child with a handicap and that these children were more likely to live out of their home. There was a noticeable lack of counselling services for both groups of maltreated children, and as a result, the author suggests that maltreated children may be subject to professional neglect.

Disability Type

Society's Reaction To A Disability

The implications of society's reaction to a person with a disability are wide-ranging and can readily be related to the issue of the abuse and assault of victims with disabilities. In a article by Sobsey (1990), the influences are summarized as follows. Society has reacted out of fear as they considered the residential needs of persons with disabilities and, as a result, created a number of isolated living environments. In these environments, abuse and assault are frequently much higher than in less isolated, more homelike settings. Persons with disabilities are often living in settings where sexual offenders also live, making them even more vulnerable to abuse and assault.

Families must also face demoralization, isolation, and chronic anxiety as a result of the lack of support they face from service agencies and an ill-informed general public. Schools and medical and social service agencies are among the service agencies that must become more aware of the needs of these families and respond accordingly.

Special educators need to consider their role in making the student with disabilities more vulnerable to abuse when examining the types of instruction being offered. Programs that teach compliance and generalization must be carefully balanced with instruction that teaches discrimination skills and assertiveness.

The legal system is another facet of society that has failed to acknowledge the needs of the disabled and their right to be heard. Victims who are mentally handicapped often are not allowed to testify on their own behalf in trial nor has the judicial system allowed expert witnesses to do so for them (Mullen, 1988).

Groups that claim to serve the needs of a particular interest group may, in fact, draw the line when faced with the needs of people with severe disabilities within that group. In June, 1988, a forum on women with disabilities met to discuss various issues. The central issue of the forum was oppression. There was a call for women with disabilities to demand dignity and rights and to reject charity and pity. The forum suggested that 80-90% of people with mental handicaps are unemployed, 39-68% of girls with disabilities will be subjected to sexual abuse before age 18, and, lastly, the women's movement must make services more accessible to women with disabilities, especially women with severe disabilities (Boyle, Rioux, Ticoll, & Felske, 1988).

Crossmaker (1986) studied the similarities between people with disabilities and other groups of people who suffer extensively from abuse. As mentioned in the introduction, she suggests that they suffer from isolation, lack of information, dependency, and powerlessness. The author also suggests that teaching prevention strategies is vital. It is important to teach strategies, skills, and awareness of rights, making the individual feel safer, stronger, and more capable of recognizing dangerous situations.

In her book, Crossmaker (1986) introduces the topic of isolation by citing many cases where people with disabilities living in institutions suffered from those placed in positions of trust and authority. For example, the parents of a thirteen-year-old boy with mental retardation described how their son had been brutally beaten from head to toe and was hearing impaired as a result of the beating. The two staff people finally indicted were suspended with pay.

While the abuse investigation committee of the developmental center found no confirmed abuse, during the subsequent investigation conducted by the parents and the other concerned citizens, it came to light that three other boys were severely beaten the same night. Unfortunately, they had no advocates who could stop further beatings, or bring to justice those responsible (Crossmaker, 1986, pp. 9-10).

It is even more disturbing to see the lack of official action of those in facilities for people with disabilities. Too often, even if the individual or an advocate does speak up, no action is taken. There can be little doubt that this situation affects the victim's sense of helplessness and powerlessness. Not only do the victims experience their helplessness, but so do the staff who would be willing to report abuse.

The experience of this author supports Crossmaker's claim that people with developmental disabilities are tremendously at risk in the institutional setting. In one abuse case, the officials at a facility did choose to prosecute the abuser. Reports of fellow staff showed that she had kicked and verbally abused at least one of the residents on her ward. She denied the charges, and since those testifying against her had not reported their observations for proper documentation at the time of abuse, she was acquitted and continues to work at the facility. The sense of powerlessness experienced by the staff, let alone the victim, was significant. Suffice it to say that 7 years after the fact the offender is still employed at the facility while most of those involved in advocating for the victim have moved on to other positions. Although taking

this case to court was highly commendable, the probability that the staff would report abuse or the administration would move toward a trial scenario again are questionable.

EDUCATION

Sex Education and Sexual Abuse Prevention Programs

The risk factors that face the child or adult with disabilities in our society present a valid rationale for instruction in current, functional information on sexuality, assault, and assault prevention. The effects of abuse on the survivors present further evidence as to the importance of education and prevention strategies. The victims of assault not only face physical and psychological effects, but also the possibility of further isolation as they are frequently removed from their homes or caregiving situations. They also struggle with the frustrations of a judicial system that fails to acknowledge their needs. Finally, as society moves toward integration and the promotion of independence in other areas of a disabled person's life, it is very wise to not only consider sexual assault prevention, but to also address appropriate sexual expression. Inappropriate sexual behavior leads to dangerous situations and dashes the hopes of full integration. On the positive side, proper expression of their sexuality can only prove to increase a disabled person's self-esteem and quality of life.

Although the reports of individuals with a variety of disabling conditions have been considered in this present study, it may be more appropriate to focus attention on those persons with intellectual disabilities when reviewing programs of sexuality

education. Most of the sex education programs that have been designed are aimed at this group of potential victims as they frequently may have less knowledge and information about the topic as adults, and as children, they may require some modification of the standard sex education program. In general, people with developmental disabilities are simply not equipped to deal with the issues and hazards facing them, and it can no longer be assumed that isolation will protect them from sexual assault and exploitation.

Definition of Sexuality

Perhaps before considering sex education, it would be helpful to define adequately the term sexuality. Ames, Hepner, Kaeser, and Pedler (1986) define sexuality as encompassing more than just biological makeup, one's relationships, and the emotional and psychosocial consequences of those relationships, one's view and acceptance of his or her sexual self: It helps to form the total picture. The authors go on to suggest that even the most intellectually compromised individuals possess the potential for a sexual response, but there may be considerable limitations to the person's ability to integrate and respond to sexual and social stimuli. They simply may not have accomplished the major developmental tasks associated with adulthood and sexuality.

Parental Concerns

Educating people with disabilities in matters of sexuality and abuse, particularly the developmentally delayed person, demands the co-operation and understanding of the people with whom they live. It has been suggested that the primary reason that these programs fail is that the educators have not taken into account the needs and

concerns of this group of people (Foxx, McMorrow, Storey, & Rogers, 1984; Mitchell, Doctor, & Butler, 1978; Shaman, 1986; Timmers, DuCharme, & Jacob, 1981). In some training programs that present material on sexuality, there are separate yet related components for caregivers and parents that precede the course or run simultaneously with the course. Before defining what might be covered in an education and prevention program, it is necessary to consider the documented concerns of parents or others who live with a developmentally delayed person.

In a study that revealed the results of clinical investigations on parental responses to adolescent sexuality by Goodman (1973), one enlightened and articulate parent expresses her opinion on the needs of her child with a disability:

> My child is as entitled as anyone else to a natural sex life. He has the same needs for a physical and emotional closeness. If he meets someone that he can go on loving, and who returns love, they should marry and be given whatever supports necessary to help the marriage work. (p. 472)

In general, however, the parents interviewed in the study reported both concern and confusion about the topic of sexuality and their child with disabilities, and most simply did not know what was best. Some of the most common fears of parents centered around their offsprings" limited judgement in evaluating sexual opportunity, their vulnerability to seduction, and the possibility of uncritical promiscuity, homosexuality, and excessive masturbation.

Goodman (1973) suggests that those who take on the role of educating persons with mental impairments in human sexual behavior need to be concerned about more than just explaining the sex act and reproduction. Goodman advises that education in interpersonal relations, the handling of urgent physiological and emotional drives, and the assumption of possible marital and parental responsibilities must be a part of the overall package.

One author (Sobsey, 1988a) suggests that in an effort to reduce abuse steps must be taken to normalize the type of relationships that the victims have with people in their lives. People with disabilities have to be more autonomous, more independent, and less controlled by those individuals who have traditionally had so much power over decisions that influence every aspect of their lives. It is also important to minimize the sense of isolation felt by families with a child with disabilities as well as the isolation of institutional settings. Some parents also need to be taught effective parenting skills; in particular, it must be recognized that parents are suffering from extreme frustration and a feeling of helplessness when trying to meet the needs of their son or daughter. Some cases of physical abuse have been attributed to a sense of learned helplessness experienced by the parents.

Sexuality and Sex Education Within the Institution

Ames et al.,(1986) propose guidelines for sex education and programming directed toward serving those developmentally delayed persons who reside within institutional settings. They base their recommendations on four basic premises:

1. All persons with developmental disabilities possess sexuality as well as attributes that make them distinctly male or female,
2. there will be a wide range of sexual and social behaviors among all general categories of intellectual handicap,
3. intellectual functioning does play a role with regard to how a person actualizes their sexual and social potential, and
4. sexuality is reflected in a developmental continuum which reflects biological, sociological, and psychological components.

Ames et al., (1986) suggest a clinical approach to creating an environment that empowers the person with disabilities to give full expression to their sexuality. The clinical team would develop policy, set standards for treatment and training, and assist the client in determining needs and appropriate conduct with regard to the expression of his/her sexuality. In the proposed system, the authors consider the needs of adults with developmental disabilities who do not live at home with their parents and whose parents wish to be directly informed of and frequently wish to prevent their son or daughter from engaging in any sexual activity. Although the process of involving a team of professionals in a matter that is of such a personal nature seems so unnatural, these authors suggest that it may, in fact, be the best practice for honoring the rights of the developmentally disabled individual to proper expression of their

sexuality and for protecting their privacy. It may be inadvisable for parents to dictate in decisions regarding their adult children, yet it does seem that their opinions must be heard unless their child has specifically requested otherwise. It would seem that they too must be included in the team.

Acknowledging the delicate balance that exists between honoring the rights of the people with intellectual impairments and protecting their safety, Ames et al. (1986) suggest that it is important to teach abuse prevention and proper expression of sexuality within the same course of instruction. This recommendation is supported by other researchers in this area (e.g., Ryerson, 1984; Shaman, 1986). A well-trained sexuality educator would need to be a member of the clinical team involved in the life of the person with disabilities. Those staff members involved directly in the education and training of the person with disabilities would also need special education and training in issues concerning sexuality.

Finally, the particulars of a sexuality training program are also proposed by Ames et al. (1988). These authors state that it is necessary to evaluate the students' overall learning ability and their capacity to use and integrate any instructional concepts. They also propose the following guidelines for determining the consent of someone who cannot speak for him or herself:

a. A sexual case history is developed and would include facts identifying sexual behaviors and social interactions,

b. an evaluation of the clients' ability to remove themselves from unwanted situations and to say no,

c. the clients are observed to determine if both parties seem to enjoy their sexual contact,

d. the clinical team evaluates the facts and if necessary assists with instructional procedures to facilitate sexual activity or intervention to stop a potential abusive or undesired relationship, and

e. the clinical team monitors progress and decides whether to inform family members of the clients' sexual activity.

Sexual Assault Prevention

An eight member team, composed of self-advocates, family members, educators, and others with expertise and interest in the area of sexual abuse and assault, evaluated nine sexual abuse prevention programs for persons with developmental disabilities (G. Allan Roeher Report, 198). The committee included six categories in their evaluative tool. They felt that an effective program needed to include the following components:

1.Values as the Root Causes of Abuse

Although instruction in the prevention of abuse may assist in reducing its incidence, it will never eliminate it. Society's attitude toward violence, abuse of power, children and women, sex-role stereotyping, and sexuality needs to be a fundamental part of the overall strategy to reduce assault and abuse. The committee felt it was imperative that a good sexual abuse prevention program address

societal conditions that foster the occurrence of abuse (e.g., sex stereotyping of boys/girls and men/women, limiting opinions about the thoughts and feelings of boys and girls, and degrading and dehumanizing stereotypes of people with disabilities).

2. Accuracy

A second key component of an effective program would obviously be the degree of accuracy with which the material was presented. Some of the information that should be communicated would include the following:

a. Approximately 38% of all girls and about 10% of all boys are victims of sexual abuse before age eighteen;
b. there is an even higher rate of sexual abuse of children (and adults) with mental handicaps;
c. children are more likely to be assaulted by someone they know;
d. while 80% of abused children are abused by someone known to them, the percentage is even higher for those who abuse children with a mental handicap;
e. people with disabilities are likely to be seen as easy targets by abusers, who believe these persons will be compliant and unlikely to reveal the assault;
f. females who disclose are less likely to be believed than males who disclose; and
g. men are offenders in cases of sexual abuse approximately 94% of the time.

3. Appropriate Language and Concepts

Use a program that is accessible and appropriate to the age and cognitive abilities of the target audience.

4. Presenting a Balance of Positive and Negative Messages and Exploration of the Touch Continuum

Present the range of positive, negative, and confusing touch.

5. Empowerment

Empowerment is described by Crossmaker as a process of acquiring information, skills, social support networks, increased self-esteem and increased control over one's life. Some of the messages they should learn are

a. that they have the right to say "no,"
b. that they can assert their boundaries,
c. that they can trust their feelings, and
d. that they do not have to keep secrets.

6. Inform About Barriers

Realistic programs should also inform educators of the attitudinal, social, institutional, and physical barriers facing sexual abuse victims with disabilities.

Normalizing Relationships

Although sex education for children has been a topic in education circles for years, until recently, it has not been presented as feasible nor necessary for students with disabilities. Shaman (1984) believes that society has perpetuated the myths that people with mental retardation are asexual, dependent, and pathetic and proposes a prevention training model that would include the following goals:

a. increasing children's self-esteem and positive self-image,
b. providing children with the vocabulary to talk about assault and to understand that they are not to blame,
c. decreasing children's isolation and increasing peer support,
d. providing education in appropriate sexual behavior, and
e. increasing the legal and medical services response.

In a study by Foxx et al. (1984), six institutionalized adults with mental retardation were taught multisituational interpersonal skills. The researchers felt that it was important to focus on teaching persons with mental handicaps normal social and sexual interactional skills in an effort to reduce illegitimate births, sexual exploitation, premarital pregnancies, and maladaptive or inappropriate sexual behaviors. The six skills instructed required a verbal action or reaction and included giving compliments, social interactions, politeness, criticism, social confrontation, and questions and answers. The results indicate that the subjects' social responses to sexually related scenarios increased during training and generalized to untrained environments.

Ryerson (1984) discusses the need for education in sexual abuse and self-protection and describes the success of one particular program:

> Successful use of the special education curriculum on sexual abuse has demonstrated that we can no longer

> hold a fatalistic view of the problem and assume that developmentally disabled persons cannot learn to protect themselves. (p. 2)

The curriculum she speaks of was field tested with a group of students with mental retardation. Not only did it prove to be an effective tool for teaching self-protection skills, but also, the students retained the skills over time. The author continues by saying,

> Regardless of their disability, these people can learn reporting and self-protection practices, both of which should be a critical part of every disabled student's basic education. It is appalling to think that without this education the sexual abuse of this population will be perpetuated and the offenders will continue to find victims of all ages. (p. 2)

Ryerson also suggests that it is very important to rebuild appropriate sexual orientation after an abusive incident as the victim may be very confused as to the appropriate expression of their sexuality. The self-protective measures suggested are those we all practice: methods to secure houses or apartments, safe door and telephone answering, ways to deal with harassment, and travel safety.

A study by Bregman (1984) had positive implications for the teaching of group assertiveness skills to adults with mental retardation. In this study, 128 subjects were randomly assigned to

either a treatment or control group. Participant selection was based on a diagnosis of mental handicap, comprehension and verbal skills which would allow full participation, and a willingness to volunteer.

The author defined non-assertiveness behavior as that type of behavior that allows a person's rights to be violated. Assertive people, on the other hand, stands up for their legitimate rights in such a way that the rights of others are not violated. Assertive behavior also allows for the expression of feelings, ideas, and beliefs in an honest, direct, and appropriate way. The study utilized the Elwyn Institute assertiveness training model (Rosen & Zisfein, 1974), a training program in which successful participants would learn

a. to express appropriate affect and express good feelings and positive statements,
b. to express needs and desires,
c. to express anger,
d. to say no,
e. to state opinions and contradictions, and
f. to assert self to authority figures.

Results of the study indicate that the program was successful in teaching the treatment group the targeted assertive behaviors. The author had hoped also to show that the subject's had moved to some degree from an external locus of control to an internal locus of control. The externally motivated person attributes the reinforcement one receives to things beyond their control, while the

internally oriented individual believes reinforcement comes from one's actions. The subjects did show some shift from external to internal locus of control with an increase in assertiveness skills.

Bellamy and Clark (1977) implemented a sex education and social skills training program for students with severe handicaps. In this training program, role play was the basic form of instruction utilized to teach rudimentary sex education and social skills, including the following:

a. discriminating and labelling body parts,
b. performing self-care tasks,
c. labelling family members and relationships,
d. engaging in social interactions, and
e. using appropriate social manners.

The students involved in the program were 12 to 16 years of age and had IQ scores ranging from 35 to 51. Reports from parents, teachers, and administrators indicated that the subjects were engaging in inappropriate social and physical interactions, such as, public masturbation, indiscriminate touching of others, and public display of underclothing and body parts.

The results of the study indicate that the subjects mastered the skills as identified and that the students, on the whole, generalized the use of the skills to other untrained environments.

Assault Prevention Training

The goal of the Assault Prevention Program (APT) is to empower people with mental retardation and developmental disabilities (Crossmaker, 1986). Participants in the APT workshops

discuss threatening or coercive scenarios, and they receive strategies in assertiveness to increase security and the capability of handling dangerous situations. This information is also aimed at increasing the participants self-esteem and personal power.

Crossmaker (1986) asserts that the success of any training program for prevention depends on the acceptance and support of the environments in which the participant lives, works, and interacts. There must be reinforcement in order for empowerment and assertiveness skills to carry over from the classroom training sessions to everyday life.

It cannot be expected that people who have learned compliance, who have little choice even in what they will eat or when they will get up or go to bed, will be able to stand up for themselves when they are threatened or in danger.

The participants of this particular program reported that they were often punished when they tried to practice their skills outside of class. The author also suggests that assertiveness skills learned in class must be practiced in less threatening situations of every day living if they are ever to be used in an assaultive situation. For this reason, the APT workshops have a component for caregivers and parents that is presented before the training is offered to the participants with disabilities.

SUMMARY OF THE CHAPTER

In summary, the review of the literature has provided documentation of a number of the factors that increase and effect abuse and assault, while it also examined strategies for its

prevention. It has considered both individual and environmental factors that increase the vulnerability of persons with disabilities and the larger overall effect of the society in which we live. The methodology used in conducting the current study will be presented in the following section.

CHAPTER 3

METHOD

The primary purpose of this study was to identify the role of compliance in the reported cases of assault and abuse and to then consider the implications of the findings. This chapter describes the methods used to determine these findings and describes the subjects, offenders, offenses, and a variety of factors associated with the incidents.

DESIGN

A substantial proportion of research in the field of education involves the use of surveys. The current research utilized the survey method of data collection. Surveys also have been used in a number of other fields to access important information as well. Probably the most familiar tool in use today is the Gallup poll, which over the years has sampled public opinion on a variety of topics, including politician popularity. Market research utilizes this method to measure product acceptance and use, while scientific research frequently collects information through surveys regarding interests and problems in a particular field. It is feasible to study relationships, effects of treatments, longitudinal changes, and comparisons between groups using surveys (Engelhart,1962).

The survey instrument is used to collect standardized information from all subjects. When open-ended questions are used, as was the case in the current study, the information is categorized so that it can be analyzed and reported quantitatively. The

particular method used for this survey will be described in the section "Data Analysis."

While survey research is valuable in determining the distribution of a sample on a single variable, it is also helpful in exploring the relationship between two or more variables. The latter method may prove to provide more valuable information to the study of a particular topic. In the current research, the distribution of single variables is presented, but the main focus of the study centers on establishing the relationships between the variable "compliance" and the other variables under investigation in the larger study. Although survey research can be used to explore the relationships between variables, it is not as feasible to use this method to determine causal relationships. Cause-effect relationships are best determined by means of an experiment.

SURVEY INSTRUMENT

The survey used in the current research was originally designed to measure the amount, type, and adequacy of services provided to sexual abuse victims with disabilities in Canada and the nature of the offenses. As the questionnaire (See Appendix A) solicited information regarding the specific nature of the sexual offenses, it could be used to investigate more closely the role of compliance as it affected the victim's vulnerability to assault and as it related to other factors influencing the incident. The information gained from the survey was codified into the following measures:

a. the characteristics of the offenders, the victims, and the offense;
b. the relationship between the victim and the offender;
c. the nature and extent of the victim's disability, and the contribution the disability or disabilities may have made to the victim's degree of vulnerability;
d. the location of the offense;
e. whether or not the offender was charged and/or convicted of the offense, and what influenced that decision;
f. the type of treatment and support services sought, and the suitability of these services for the victim; and
g. the nature of physical, social, emotional, and/or behavioral injury to the victim.

The survey was confidential, and the victim, the offender, and the reporter as well as the city or province where the offense occurred were not identified. It contained 19 open-ended and forced choice questions.

Responses to specific questions regarding attributes of offenders and victims, the relationship of offenders to their victims, the number of episodes of abuse or assault, the nature of the abuse, reports, charges, convictions, effects on victims, and treatment services were categorized for all reports. A second rater categorized all variables for 25 (15%) reports in order to determine reliability for each category. Inter-rater reliability was calculated as 100 times Agreements divided by Agreements plus Disagreements

equals Percent Reliability. Inter-rater reliability ranged from 92% (for categorization of generic services providers) to 100% (for 11 variables), with a mean of 97%.

Administration of the Survey

The survey was distributed to a cross-section of Canadian agencies that aid people with disabilities. Included in this group were community mental retardation associations, cerebral palsy organizations, educational, vocational, and community living programs, and groups that support and treat disabled victims of violence. The agencies were then instructed to distribute the surveys to any group or individual who would have pertinent information regarding an incident or incidents of sexual assault. The usable reports returned to the researchers, of which there were one hundred and fifty-four, were analyzed in the current research.

DATA ANALYSIS

The data was analyzed using a Chi Square analysis. Statistical inferences about categorical data in which the number of categories is larger than 2 could be compared using this statistical measurement. Using Chi Square tests of the data in the current study made it possible to determine whether two variables (one of which was always compliance as a risk factor) were independent or related. This afforded the opportunity to evaluate the problems posed in the questions.

The analysis found that there were five significant relationships which will be presented in Chapter 4, "Results": (1)

Compliance was found to be significantly related to the offender's disability status; (2) nondisabled offenders were significantly more likely to assault or abuse the overly compliant victim; (3) overly compliant victims were significantly more likely to be more severely disabled; (4) they were more likely to be abused in caregiving situations; and (5) they were less likely to acquire victim services following an assaultive or abusive incident.

SUBJECTS

The subjects in this study represent a non-random sample of victims of sexual abuse or assault as identified in a study conducted across North America. The subjects ranged in age from 1.5 years to 57 years, with a mean age of 19.66 years. The sample consisted of 130 females (83.4%) and 24 males (16.6%). There were 154 subjects in total.

The victims had a broad range of disabilities, and some reported more than one disabling condition. As this was a non-random sample, it cannot be established that the breakdown presented in the following table is a representative distribution for the general population of assault victims with disabilities. The disabilities of the victims were distributed as shown in Table 2.

Table 2

Disabilities of the Victims

Intellectual Impairment	107 (70.4%)
Autism	2 (1.2%0)
Mental Retardation (Unspecified)	68 (44.7%)

Mild mental Retardation	21 (13.8%)
Moderate Mental Retardation	19 (12.5%)
Severe Mental Retardation	23 (15.1%)
Profound Mental Retardation	5 (3.3%)
Physical Disabilities	30 (19.7%)
Hearing Impairment	19 (12.5%)
Visual Impairment	5 (3.28%)
Psychiatric Impairment	17 (11.1%)
Learning Disabled	2 (1.3%)
Neurological Impairments	3 (1.9%)
	154 victims
	321 (208 %) disabilities

SUMMARY OF THE CHAPTER

In summary, 154 reports of abuse and assault were collected and categorical data were determined regarding the nature of the incidents. The data were then analyzed to establish the significant relationships that existed. The following section will present the results of the research.

CHAPTER 4

RESULTS

CONTRIBUTION OF THE VICTIM'S DISABILITY TO VULNERABILITY

Two primary research questions were asked in the study. The first question was; does a victim's proclivity toward compliance influence their abuse status? The survey asked how the victim's disability may have made them more vulnerable to assault or abuse. The responses that were solicited identified a number of ways in which the victim's disability might have contributed to their degree of vulnerability and compliance was one of the risks cited. The following were also cited:

a. lack of knowledge and judgement,
b. communication difficulties,
c. physical defenselessness,
d. overly trusting manner,
e. approval seeking behavior, and
f. living arrangement due to their disabilities.

It is interesting to note that the majority of the effects of disability are those that potentially can be corrected. With the exception of physical defenselessness, the other items could shift with appropriate educational opportunities. Table 3 identifies the effects across the total sample.

Table 3

Types of Risk Factors

Risk Factor	Number of Reported Cases
Lack of Knowledge and Judgement	52 (29.9%)
Compliance	40 (23%)
Physical Defenselessness	19 (10.9%)
Communication Difficulties	19 (10.9%)
Trust	11 (6.3%)
Seeking Approval	7 (4%)
Environment	15 (8.6%)
Other	11 (6.3%)

As indicated there were 40 surveys that reported that compliance made the victim more vulnerable to assault, and 114 surveys did not identify compliance. Compliance was established as significantly influential as it was identified in 26% of the reports.

DESCRIPTION OF THE OFFENDERS, VICTIMS, AND OFFENCES

The second purpose of the current research was to establish if the nature of cases where compliance was identified were significantly different than those where it had not been. As outlined in the description of the survey, a number of separate though related variables were investigated including the nature and severity of the victim's and offender's disabilities. In total, nine different types of

disabilities were reported for the victims, and seven for the offenders (see Tables 4 and 6). In 70.5% of the cases, the offenders were identified as nondisabled. A victim or offender might have had one, two, or more than two disabilities.

Table 4 delineates the specific disabilities, and degrees of disabilities, affecting the compliant victims from those victims where compliance was not identified as a risk factor. The data from this table was used to measure if the more severely disabled victims were overrepresented in the overly compliant group. Results of this calculation are represented in Table 5 and indicate that there was a significant relationship. The victims identified as severely disabled were also more likely to be identified as overly compliant.

TABLE 4

Victim Disability

	Overly Compliant n = 40	All Others n = 114
Intellectual Impairment	30	77
Mild	6 (14.3%)	5 (13.6%)
Moderate		(12.7%)
Severe	8 (19.0%)	15 (13.6%)
Profound	0	5 (4.5%)
Autism	1 (2.3%)	1 (.9%)
Hearing Impairment	2 (4..7%)	17(6.36%)
Visual Impairment		5 (4.5%)
Mobility Impaired	6 (14.28%)	24 (21.8%)
Psychiatric Impairment	10 (23,8%)	7 (6.36%)
Neurologically Impaired	3 (7.1%)	3 (2.7%)
Learning Disabled	0	2 (1.8%)
Not Specified	1 (2.3%)	2 (1.8%)
Total	42	110

TABLE 5

Chi Square Analysis (A)

Compliant and Noncompliant Victims and Severity of Disability

	Severe	All Others
Compliant	8 (20%)	32 (80%)
Noncompliant	15 (13.15%)	99 (86.84%)

Chi square = 8.140 : $p < .05$

A significant relationship ($p < .05$) was found between the victims identified as compliant and noncompliant and the severity of their disability (see Table 5).

OFFENDER CHARACTERISTICS

The offenders in this study were also classified according to age and disability. The offenders were primarily male (89.5 %), which further supports the findings discussed in the review of the literature. The average age of the offenders was 32.77 years. Fifty-nine percent of the offenders were specifically described as not having a disability, and 17% were not indicated specifically either way. Assuming that each offender had only one disability, 24% were described as having a disability. As demonstrated in Table 6, a higher percentage of non-disabled offenders committed offences against victims who were reported to be compliant (75%). These

results answer the question; Is there a significant relationship between the propensity of a victim toward compliance and the disability status of the offender? As this was found to be statistically significant, the possible implications of this finding will be discussed further in Chapter 5, "Discussion."

TABLE 6

Offender Disabilities

	Overly Compliant n = 37	All Others n = 93
Not disabled	30 (81.1%)	61 (65.6%)
Intellectual Impairment	8.(1%)	18 (19.4%)
Hearing Impairment	1 (2.7%)	8 (8.6%)
Visual Impairment	1 (2.7%)	1 (1.1%)
Mobility Impaired	0	2 (2.2%)
Neurologically Impaired	1 (2.7%)	0
Learning Disabled	0	1 (1.1%)
Total	37	93

TABLE 7

Chi Square Analysis (B)

Compliant and Noncompliant Victims and Offender Type

Offender Type	Nondisabled	Disabled
Compliant	30 (75%)	10 (25%)
Noncompliant	1(53.5%)	53 (46.5%)

Chi square = 5.658 : $p < .05$

A significant relationship ($p < .05$) was found between the victims identified as compliant and noncompliant and whether the offender was disabled or nondisabled (see Table 7).

TYPES OF OFFENCES

A number of different types of offences were reported in the study. Sexual intercourse was indicated in 36.3% of the cases. Incidents were reported in which the offender performed the sexual acts upon the victim as well as offences that involved forcing the victim to perform sexual acts to the offender. The latter scenario was more prevalent among the victims where compliance was identified as a risk factor: 20% for compliant victims versus 12% for noncompliant victims.

OFFENDER/VICTIM RELATIONSHIP

The current research supports the findings in the literature that sexual offences against people with disabilities were generally

committed by persons known to the victims. In 91.4% of the reports, the offender was a known individual. In 34.8% of the reports within the compliant group, the offenders were caregivers or service providers. In the noncompliant group, this figure dropped to 22.3%. However, these numbers did not prove to be statistically significant. Table 8 identifies the relationships between the victims and the offenders for compliant and noncompliant victims.

TABLE 8

Offender Relationship to Victim

	Overly Compliant n = 42	All others n = 132
Normal Family	7 (16.7%)	22 (16.7%)
Foster Family	2 (4.8%)	6 (4.5%)
Acquaintance/ Neighbour	7 (16.7%)	18 (13.6%)
Disabled Service Provider	15 (35.7%)	32 (24.2%)
Stranger	2 (4.8%)	13 (9.8%)
Date	2 (4.8%)	5 (3.8%)
Nondisabled Service Provider	(2.4%)	17 (12.9%)
Step Relative	0	3 (2.3%)
Transportation Provider	3 (7.1%)	7 (5.3%)

Disabled Peer	3 (7.1%)	9 (6.8%)
Total Incidents	42	32

LOCATION OF SEXUAL ASSAULT/ABUSE

Sexual offences were reported to have occurred in a number of locations, ranging from private homes to vehicles and in places where segregated disabled services were being provided. The study asked; Is there a significant relationship between the victim's compliance and the location of the assault? Approximately 52% of the offences took place in a private home, 21% in a group home, institution, or hospital, 10.7% in a vehicle, 4.7% in other places that provided services to the disabled, and 9.3% in a public place. In the compliant/noncompliant breakdown of the sample, a higher percentage of the offences against compliant victims took place in the group home and institutional setting than in the noncompliant group (e.g., 30.9% versus 11.9%). Table 9 identifies the location of the assault for compliant and noncompliant victims.

TABLE 9

Location of Offence

	Overly Compliant n = 40	All Others n = 109
Private Home	20 (50%)	58 (53.2%)
Group Home	5 (12.5%)	5 (4.6%)
Institution	8 (20%)	8 (7.3%)
Hospital	0	5 (4.6%)
Vehicle	6 (15.0%)	10 (9.1%)
Public Place	1 (2.5%)	3 (2.8%)
Other Disabled Service	0	6 (5.5%)
Other	0	4 (3.7%)
Total	40	109

TABLE 10

Chi Square Analysis (C)

Compliant and Noncompliant Victims and Location of Assault

	Group Home/ Institution	Home	Other
Compliant	13(32.5%)	20(50%)	7(17.5%)
Noncompliant	3(11%)	58(50.8%)	43(37.71%)

Chi square =11.334 : $p < .05$

A significant relationship ($p < .05$) was found between the victims identified as compliant and noncompliant and the distribution of settings where they were assaulted. More assault occurred in caregiving situations for the compliant group (see Table 10).

TYPE AND ADEQUACY OF SERVICES

The survey investigated the type and adequacy of the services provided following an assaultive incident and the study asked whether the services provided were different for the compliant group than for the noncompliant group. As is indicated in the literature, the adequacy of service for disabled victims was found to be generally below standard and frequently unavailable for victims with severe disabilities (see Table 11). Approximately one-third of the noncompliant victims found it difficult to acquire services, while over 50% of the compliant victims reported difficulty in accessing services. Although the numbers were too small to prove statistical significance, it should be noted that in only one case did a compliant victim seek legal aid, and only 12 of the 114 noncompliant victims sought legal aid (see Table 12).

TABLE 11

Services/Difficulty

	Overly Compliant n = 37	Noncompliant n = 108
Counselling	24 (64.8%)	47 (43.5%)
Legal	1 (2.7%)	12 (11.1%)

Educational	2 (5.4%)	4 (3.7%)
Current Caregivers	6 (16.2%)	19 (17.6%)
None	4 (10.8%)	4 (13.0%)
Protective	0	2 (11.1%)
Difficulty Attaining Services	22 (55%)	39 (34.21%)

TABLE 12

Chi Square Analysis (D)

Compliant and Noncompliant Victims and Difficulty Getting Services

	Difficulty	No Difficulty
Compliant	22 (55%)	18 (45%)
Noncompliant	39 (34.21%)	75 (65.79%)

Chi square = 5.349 : $p < .05$

A significant relationship ($p < .05$) was found between the victims identified as compliant and noncompliant and the difficulty they had in acquiring services after the assault.

SUMMARY OF THE CHAPTER

The results indicate four significant relationships: (1) nondisabled offenders were significantly more likely to assault or abuse the overly compliant victim; (2) overly compliant victims were significantly more likely to be more severely intellectually

disabled; (3) overly compliant victims were more likely to be abused in caregiving situations; and (4) overly compliant victims were less likely to acquire victim services following an assaultive or abusive incident.

The discussion section that follows will examine the results with regard to implications for parents, professionals, and administrations, and will consider further research and possible modificaitons to current practices.

CHAPTER 5

DISCUSSION

This chapter summarizes and discusses the results of the study. These results identified the prevalence of some of the risk factors that made the victims more vulnerable. They also determined the correlation between these risk factors and other characteristics of the incidents. The discussion also includes the limitations of the study, and it presents implications for using strategies to reduce the risk of sexual assault and abuse for parents and caregivers, teachers and other professionals, and persons with a disability. Finally, this section suggests possible directions for future research.

SUMMARY OF THE STUDY

Background and Rationale

The purpose of this study was to discover the role of compliance as a factor influencing a victim's vulnerability to sexual assault or abuse. It also considered how compliance related to other aspects of sexually abusive or assaultive incidents. The information presented in this study includes the relationship of the victim to the offender, the disability status of the victim and the offender, the type and location of offences, and the relative influence of the specific risk factors. This material was subsequently divided into two categories, those reports where compliance was identified as a primary risk factor and those where compliance was not identified

as a risk factor. The two sets of data were compared on other aspects of the incidents using a chi square analysis. Five of the relationships were found to be significant at a .05 level: (1) Compliance was found to be significantly related to the offender's disability status; (2) nondisabled offenders were significantly more likely to assault or abuse the overly compliant victim; (3) overly compliant victims were significantly more likely to be more severely intellectually disabled; (4) they were more likely to be abused in caregiving situations; and (5) they were less likely to have difficulty in acquiring victim services following an assaultive or abusive incident. These relationships will be discussed individually later in this chapter.

Because a significant percentage of reports from the survey population showed that assault and abuse victims with disabilities were overly compliant, compliance was investigated as a primary risk factor. In 25.9% of the reported cases, compliance was considered a factor that increased the risk of abuse and assault for individuals with disabilities. The literature that was reviewed also supported the theory that compliance was an important risk factor, (Ryerson, 1984; Sobsey & Varnhagen, 1989).

The literature contained information on the nature and incidence of assault and abuse of persons with disabilities, including prevalence and underreporting, offender characteristics, learned helplessness, and society's response to the assault of persons with disabilities. The literature also identified research that had previously studied the influence of the potential risk factors that were established in the current study. These risk

factors included environment or type of residence, type and severity of disability, compliance, lack of knowledge and information, communication deficits, trust, and physical defenselessness. Compliance, the positive effects of programs to reduce its influence, and the influence of factors such as lack of information and knowledge were also discussed. The literature review also looked individually at the particular characteristics identified in child sexual abuse cases and specified some of the family characteristics that increased the risk of abuse.

RESULTS OF THE STUDY

The results of the study will first be examined to determine the prevalence and type of risk factors that were reported. The implications of these results and possible measures that could reduce the influence of these factors will then be considered.

Overcompliance, Lack of Education, and Communication Deficits

The statistics in Table 3 indicate that three risk factors were indicated in approximately 62% of the reports: (1) overcompliance, (2) lack of education and knowledge regarding sexuality and sexual assault prevention, and (3) communication deficits. Although these three factors focus on separate issues, they are related in that appropriate education and training programs could teach the victims skills that might reduce their effects. Proper education alone, however, is probably inadequate to protect individuals who have been victimized most of their lives by a society that has refused to accept them or that has blatantly disregarded their basic human and

legal rights. Other prevention strategies, such as strategies aimed at changing public attitudes, must accompany educational programs before there is any significant success in preventing the sexual abuse and assault of people with disabilities. However, research has shown that instruction in sexual assault prevention, assertiveness, sexuality, and sexual social skills development can enhance the self-protection skills of an individual with disabilities, and increase appropriate sexual expression.

Role of Education in Reducing Risks: Implications for Educators, Careproviders, Parents, and Administrators

Programs teaching choice-making and assertiveness skills have been used to reduce the overcompliance of individuals with disabilities. However, given the frequent dependency of disabled persons on outside support, an overall reorientation of the system is necessary in order for any program to be successful. The rights of the person with disabilities to make decisions about the direction of his/her life must be fully acknowledged and supported by those who have historically controlled the lives of people with disabilities. Without this support, self-advocacy will fail, and most likely, that failure will be falsely attributed to the person with a disability, rather than to the system.

Recently, the most assertive persons with disabilities have begun to demand the full range of personal and legal rights. The more compliant and, in most cases, the more severely challenged the individual is by their disability, the less likely they are to demand these rights.

As educators, other professionals, parents, and administrators, the implications are obvious: We must both encourage and support the person with a disability as he/she strives to decide the course of his/her life. However, not only do we need to provide support, education will also be required so that the person with disabilities (and perhaps more importantly, the society in which they live) will become aware of the nature of his/her rights and the accompanying responsibilities. As we set out to raise awareness, courts and those providing legal services, law enforcement agencies, assault prevention and treatment services, those administering and providing services to persons with disabilities, and those providing generic social services in the community must also be educated.

To date, the programs developed to enhance assertiveness skills for persons with mental handicaps appear to be most effective when they teach and enhance skills that directly apply to the students' everyday environments. The more closely situational role playing or demonstrations within class can simulate the real life experiences of the students, the more effective they have proven to be in actual life (Ryerson & Sundem, 1981). As will be specified in the following section on sexuality training and sexual assault prevention, the cooperation of home and school or any other service providing the education is vital. Many courses provide education to the parents or caregiver as well as to the students so that the course content and intentions are clear to them, and in order to elicit support to ensure students are given the opportunity to practice their new skills at home.

A curriculum that meets the educational needs of persons with disabilities in the areas of sexuality and sexual assault prevention must be carefully thought out, and again, it requires cooperation between educators and the persons with whom the student lives. As the review of the literature indicated, this cooperation is the single most important factor determining the success of such programs. Teachers and parents or caregivers are charged with this challenge, and support in the form of the necessary professional and financial resources must be made available to them. Therefore, those in policy making government, educational, or administrative positions must be involved in the planning of the program. The components of a variety of programs were presented in the review of the literature. As was indicated, it will be necessary to include both the positive proactive aspects of sexual expression as well as the protective skills necessary in order to prevent abuse and assault. It is also important that the instruction be individualized and take into account the cognitive and communication abilities of each student. Consideration will also need to be given to the specific content of any course since what may be comfortable for one individual may not be comfortable for another.

For persons who are severely intellectually impaired, one of the fundamental issues to be assessed is who should decide what choices best reflect those that the person with disabilities would choose for him-/herself regarding sexual expression had he or she the capacity to do so independently. Today, there seems to be a struggle between parents and professionals over this issue. However, even if the content and the intended outcome of the

instruction is easily determined by those involved, there still remain the questions of who will present the material and how to do so accurately. The predominant assumption seems to have been that the person with mental handicaps would be safer not knowing about sex and sexuality. Too frequently, the issue has simply been ignored, and nothing has been done to provide necessary and important information regarding sexuality, which leaves the person with disabilities in jeopardy of being improperly educated at the hands of an abuser.

Reforming Current Educational Practices

As educators, not only do we need to provide progressive programs that increase the skills outlined in the preceding section, but we must also consider the possibility of changing some common educational practices. Educators must consider the implications and dangers of teaching generalized compliance to demands as has been the instructional tradition. Is it necessary to eliminate instruction that encourages compliance, or can training to discriminate with whom and when compliance is safe be successful? This form of discrimination has proven to be difficult for everyone regardless of disability status, for example, almost all of Ted Bundy's victims went with him willingly (Rule, 1980). In some cases, he claimed to be a police officer; in others, he wore his arm in a sling and "needed help carrying things." It may be very difficult for students who are severely intellectually compromised to reach a level of discrimination that ensures their safety, and for these students, greater levels of independence may only be acquired when they have

been able to follow and learn from the instructional guidance of others.

The use of rewards as motivators to attain an instructional goal may also need to be reviewed. It has been indicated that bribes or promises of rewards have been used to successfully tempt persons with disabilities into dangerous situations. However, there is an obvious dilemma that arises in determining how to proceed. Is one always to assume that individuals with disabilities are living in environments where they will be abused? Will it be necessary to avoid the use of effective strategies to increase skills on the assumption that these same strategies will be abused?

Another avenue for future research and possible reform could be an investigation into the number of victims of assault and abuse that were on some form of behavioral control program or drug therapy to reduce aggression and increase compliance at the time of or previous to their assault. It has been demonstrated in the literature that aggression may have been the person's only means of self-protection and procedures to reduce it left the individual completely vulnerable. As educators, we must look closely at these type of programs. This is one of the powerful issues raised in Anthony Burgess's book "A Clockwork Orange" (Burgess, 1962).

Teaching Communication Skills

Unlike sexual assault prevention and sexuality education programs, there has been less evidence to support the idea that communication skills training reduces the risk of abuse and assault. Research is either limited, or the effects have proven to be less than effective or more difficult to measure. However, it was reported in

various articles that victims of assault had used nonspeech systems to report the incident and been successful in having themselves removed from abusive environments. It was also indicated that the judicial system needed to assist those with communication deficits in presenting their case in a court of law by facilitating the use of augmentative speech systems, sign language, electronic aids, and so forth. Determining the effect of specific programs that teach self-protective communication skills would be an area in which further research could be conducted. It would also be useful to investigate the effects of the new provincial legislation in Nova Scotia that gives special assistance to victims and witnesses who have special communication needs so as to compensate for these needs throughout investigation and prosecution. Will more convictions be attained? Will more cases go to court in the first place?

Role of Environment

Table 3 also revealed that type of environment was a key risk factor in 8.9% of all reported cases. In the current study, the characteristics of the particular environments that were considered abusive in and of themselves were not identified. Future research might determine the role of environments in influencing risk and what environmental characteristics could be modified to reduce those risks. It may be that they have many common characteristics even though many reporters failed to recognize environment as a primary risk factor (e.g., they may be more segregated). Type of environment may be a much more significant risk factor than indicated originally, and future investigation would need to determine a more precise measurement of its effect. Once the

characteristics of the environments where abuse and assault occurs is determined, it would then be possible to suggest prevention strategies.

The literature indicated that a high degree of isolation within an environment can increase the rate of abuse and assault suffered by those individuals who are most vulnerable, whether they are women, children, persons with disabilities, or persons belonging to minority populations (Crossmaker, 1986). A number of methods have been proposed to reduce isolation. One method suggests a parent or caregiver support group. With the support of others in similar situations, the parent or caregiver might be more likely to air and possibly alleviate the tension that often leads to abusive situations. Also, if others are involved with their family it may be harder to hide and justify abuse. Even though methods have been proposed, it could prove valuable to assess the degree and kind of isolation in abusive settings and the effects of strategies to reduce isolation.

A second important strategy is the encouragement of friendships for the person with disabilities. It has been suggested that having a network of unpaid persons or friends in the life of a person with disabilities has a number of positive effects. Many of the advantages that we as nonhandicapped persons take for granted when we develop friends also apply to a person with a disability. These friends become one of our primary sources of emotional support and our confidants. Persons who are not dependent on an individual or a system for their livelihood are less likely to be silent in the face of abusive situations and more likely to encourage the victim to take action.

Another means of reducing isolation is the process of deinstitutionalization. The fundamental nature and often the raison d'etre of an institution is segregation. According to the literature, the increased risk for abuse that is present in this type of setting (e.g., two to four times greater) precludes them as a residence of choice for persons with a disability. Also, the high rate of abuse in residential settings for children leads one to question their suitability as a setting in which children are placed on a long-term basis, whether they are disabled or not. It has been suggested by some authors that the movement toward community living will only place persons with disabilities even more at risk for abuse and assault (Ryerson & Sundem, 1981). Future research will likely be carefully considering this possibility, but to date, this certainly has not been supported by the available evidence.

Although institutions are the most blatant example of segregation, there are also a great number of segregated services being provided for persons who are disabled outside institutional residential settings, and the present perspective is that it would be better for those being served if they were able to use generic services. The theory is that not only do they deserve to be accommodated in generic programs, but a person with a disability will, in fact, be better served by those services that provide for all in society. Current research indicates that abuse and assault occur at a higher rate in segregated "disabled services" than in generic services, providing a strong rationale for greater integration.

Physical Defenselessness

In this study, physical defenselessness is cited as a primary cause of abuse and assault in 10.9% of the reported cases involving victims with disabilities. It would be very important to be particularly vigilant in scrutinizing and planning for the environments where people with physical handicaps live and otherwise spend their time. The careful screening of employees for previous sexual offences is an obvious prevention strategy. A simple procedure for ensuring that environments are less isolated might serve to decrease the rate of abuse and assault for this group of victims. The fact that people with physical disabilities frequently require attendant care makes them extremely vulnerable to abuse. Gender differences between personal care attendant and client may not be acceptable. However, as many of the reported assaults were homosexual, perhaps the person receiving the service should have the right to choose whether gender differences are acceptable.

Future research might wish to determine if persons who are physically defenceless are more likely to be living in more isolated settings and if this is considered to be a more significant influence on their risk for abuse and assault. Historically, those persons requiring more medical intervention or personal care, such as persons with multiple and physical disabilities, have in fact lived in the more isolated institutional settings.

Caregiving Environments and Compliance

In the statistical analysis that was conducted, five significant relationships were established. Chi squares performed on the variables of the data (see Results) indicated that a significant

relationship of 11.334 ($P < .05$) level was present between the location of abuse and assault and overcompliance. It was found that a significant proportion of the victims identified as overcompliant had been sexually assaulted or abused in group home and institutional settings. Private homes were the the second most common location of assault, exactly how many of these situations were natural family homes and how many were paid caregiving arrangements was not identified in the analysis of the data. It was also found that most assault and abuse occurred in the home of the victim as opposed to the home of the offender.

Commonly associated with their disability is the likelihood that the disabled person will live outside the natural home. The strong relationship between caregiving situations and compliance raises a number of questions. Perhaps one must first ask, do the people that live in caregiving settings develop common personality traits, including a tendency toward overcompliance? Although the literature reports that victim characteristics are not the primary factor influencing abuse status, they may be factors that influence placement, which in turn influences risk of abuse. Consequently, it might be helpful to investigate whether level of compliance is likely to be a deciding factor influencing placement.

A second important consideration is whether the type of environment can increase overly compliant behavior. If this level of compliance is necessary for the living arrangement to function successfully, its viability must be questioned given the dangers that are associated with overcompliance. However, even if some potential residents of a caregiving setting are considered overly

compliant before their placement, with careful planning and intervention, the placement may successfully encourage these people to grow and assert themselves.

This suggests another important question. What efforts are being made to teach and encourage choice-making and assertiveness skills to persons living in caregiving settings? Future research might wish to investigate this topic. It would be valuable to determine what efforts are being made to include these goals in individual program and education plans. It may be that to do so would cause chaos within the home or institution. Residents choosing what they ate at every meal and with whom they shared their lives would fly in the face of many traditional practices that left these residents with little if any power over such decisions.

Another research study might include an investigation into the number and range of choices available to persons with disabilities living in caregiving situations, and how these correlate with their level of compliance. It may be that people with fewer choices in their lives are assessed as being more compliant, but this level may be situationally determined as opposed to being personally determined. Given the results of this study, it would be safe to conclude that assertiveness skills should be primary goals for the individuals moving into caregiving situations, and if the skills are not present before the placement, they should definitely be mandatory for instruction after the move has taken place.

A third question arises from this finding: What characteristics of a caregiving situation are different from other environments and may lead to an increase in compliance and

vulnerability to assault, and if so, how can they be avoided? If certain characteristics of caregiving settings increase an individual's proclivity toward compliance, they must be alleviated, and those working in these environments have to be be carefully trained to respond to the needs of the situation. Perhaps staff will also need instruction in assertiveness in order to maintain their own sense of autonomy within the role of careprovider. The role of facilitating the greatest degree of choice-making within a group living arrangement challenges many of the current practices in institutional group home and caregiving arrangements. Administrators and advocates for persons with disabilities must look to see if policies and procedures within the various settings where care is being provided guard against abuse and assault. The literature suggests that screening for previous sexual offences should now be a mandatory hiring practice in all organizations serving persons with disabilities. It was also recommended that record of abuse remain on the permanent employment record of offenders, and that wherever possible, persons who have committed an offence should be charged and not just relieved of their duties and allowed to continue the abuse in another facility. Clear boundaries and policies must be available to the staff so that inappropriate behavior is obvious. Clear opportunities for residents to acquire education in sexuality and sexual abuse prevention must also be included in policy. Policies assuring the residents' right to privacy and proper expression of their sexuality are also needed because abuse can also come in the form of the denial any sexual expression and invasion of privacy.

Another recommendation was that formal and informal counselling services be made available to staff working in the caregiving profession. Research has indicated that frequently individuals working in situations that provide service to persons with disabilities experience feelings of sexual attraction toward clients or students (Pope, Keith-Spiegel, & Tabachnick, 1986) and that they have no strategies to deal with them. Counselling would be a format for staff members to express any concerns they might have regarding potential abusive situations. Staff should also be trained in the detection of abuse and have clear guideline to follow when they suspect such a situation. The reporting of abuse and assault along with disciplinary action against offenders can only serve to reduce the chance of repeated offences and widespread abuse within a facility.

Finally, how do we decide upon hiring a careprovider that we are choosing an individual with whom we feel safe in entrusting the lives of often very vulnerable human beings? Are there individuals of a particular age and sex that should be avoided in these situations, or at least more carefully considered? Are there personality characteristics that would contraindicate employment in this field of work? Should people with a personal history of being abused not be hired? The data from the current study indicate that males were offenders in 90% of the cases, and this finding supports the literature, where 90% would be on the low side of the spectrum. It was also noteworthy that 21% of the offenders were under 18 years of age.

The high rates of abuse perpetrated against women with disabilities by male offenders makes it obvious that placing women in vulnerable positions with male staff must be avoided. Obviously, it would be discriminatory to suggest that men should not be hired to provide care when they are qualified for these jobs, but careful monitoring of the duties expected of them must be conducted. Often, the male staff in careproviding situations are expected to be the strong arm when violent situations arise, and this may lead them to be more aggressive than the female staff who are usually not called to deal with the most difficult situations.

Severity of Disability and Compliance

The findings from the analysis of the data also indicate that a significant proportion of the victims who were identified as overcompliant were also assessed as more severely handicapped. The chi square analysis indicated a significant relationship of 8.140 ($p < .05$). Compliance was indicated in 20% of cases where the victim was described as severely mentally handicapped, and noncompliance was reported for only 13.1% of the cases. This relationship might have been predicted, yet the finding may also be misleading. A communication deficit or physically disabling condition may create an illusion of compliance or of intellectual impairment and create a misleading impression of this relationship. However, it is not difficult to envision severity of intellectual disability and compliance being strongly related. A person with weak decision-making skills can be more easily led to trust those upon whom they are most dependent.

As suggested in the review of the literature, dependency has been cited as a factor contributing to abuse. By necessity, individuals with severe handicapping conditions are more dependent. The individual with a severe intellectual impairment may be so dependent that any possibility of standing up to authority is incomprehensible. For whatever reason, the reports of abuse of persons with more severe disabilities indicate a higher rate of overly compliant behavior that increased their risk of abuse and assault. Consequently, instruction that develops assertiveness skills should be included with the life skills and vocational programming traditionally initiated for persons with severe disabilities. It has been indicated in the review of the literature that the sexual assault prevention programs developed to date are frequently not at a level understandable for the individual with severe intellectual impairments. For educators in the field, the development of such programs could be an area for future research.

Offender Characteristics and Compliance

A significant relationship of 8.140 ($p < .05$) was found between the disability status of the offender and compliance of the victim. Victims identified as overly compliant were more likely to be assaulted or abused by a person who was nonhandicapped than were the other victims. In 75% of the reported cases where the victims were considered overly compliant, the offender was nonhandicapped compared to 53.3% for the victims where compliance was not regarded as a primary risk factor. This finding implies that the nondisabled offender might more likely choose a person who would not resist assault as strongly. The more compliant victim might be

less likely to arouse any suspicions, and detection might be more unlikely. It would also be possible for the offender to assert that the victim really wished the incident to occur.

As was noted in the literature, the individuals helping to decide if a disabled person's behavior was compliant enough were the same people that were found to be abusing them. People who applied behavioral programs or administered medication that increased compliance often turned out to be offenders. The implications are obvious. It becomes extremely important to review any programs or procedures that will increase compliance and vulnerability of clients and students with disabilities. Special importance must be given to who can administer the program or medication and how many people are involved.

Services and Overcompliance

Compliance also was more frequently indicated in the cases where victims had difficulty receiving services following an incident of assault or abuse. The relationship would seem to reflect what might be expected. Persons who have problems speaking up for themselves are likely to experience more difficulty in acquiring services that require them to come forth and make their needs known. The victims identified as overly compliant had difficulty acquiring services in 55% of the cases whereas the noncompliant group experienced difficulty 34.2% of the time. Once again the results indicate that fostering skills to lessen compliance is essential in serving the needs of persons with disabilities.

LIMITATIONS OF THE STUDY

One of the limitations of this study is that the evaluations of risk factors presented by the reporters are impossible to standardize as no definitions for potential risks factors were given in the survey. One individual's assessment of a particular victim's tendency toward overcompliance might be quite different from another's assessment. In fact, there may have been a much higher rate of compliance among the victims than the reports indicate. This difficulty can similarly be applied across the other risk factors; consequently, it may be difficult to assess the precise influence and significance of each factor.

A second limitation of the study is that specific criteria were not identified for measuring the severity of disabilities of offenders and victims, and therefore, one reporter may have determined a different level of disability than another for the same victim or offender.

A third limitation of the study was that it was not possible to have a random sample. Therefore, all environments are not proportionally represented.

SUMMARY OF THE CHAPTER

In summary, the results provide evidence that indicate the importance of decreasing the effects and magnitude of compliance. It is a disposition that has proven to increase the risk of abuse and assault of persons with disabilities, and it can be affected by consistent prevention strategies. The implications for parents point toward fostering assertiveness skills and presenting proper education in sexuality and sexual assault prevention. The findings

also point out the need for parents and caregiver to give the person with disabilities the skills necessary to assume his/her highest level of personal responsibility for his/her own decisions regarding sexual expression and self-protection and to give him/her the option to do so.

For educators, the implications are obvious. We must consider presenting programs in personal development in the skills outlined in the previous paragraph, and we should be prepared to design and implement programs that are aimed at all levels of disability. We may also be called upon to educate not only the person with disabilities, but also the people who serve them and the general public. Perhaps we will also need to assess our practice of teaching generalized compliance and the use of rewards. As professionals, we may also be called to demand changes in the current judicial system so that persons with disabilities are no longer ill served. Encouraging students to participate in advocacy or self-advocacy groups may also be another means of better serving our students. Researchers could be well advised to further assess the effects of compliance and the promise of comprehensive prevention strategies aimed at reducing it.

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APPENDIX A

SEXUAL ABUSE AND DISABILITY STUDY
REPORT FORM

Please fill out the following report form as completely as possible. To ensure confidentiality, do not identify victim, offender, or reporter of criminal acts. Attach additional sheets if you wish. Report information related to only one victim on each form. Copy of request additional forms if you wish to make more than one report. RETURN BY DECEMBER 31,1990 to Dick Sobsey: Sexual Abuse and Exploitation Study/6-102 Education North/University of Alberta/Edmonton, AB T6G 2G5 Canada.

1. Date Or Approximate Date Of Single Offense:
   Year__ __ Month____ Day____

2. Approximate Time Of Day: (List) __ __ Hour (Circle) AM PM

3. If Repeated Offense, On How Many Occasions Did This Occur?_____

4. Where Did This Occur? (For Example, Victim's Bedroom, In home, Public Park, Group Home Basement)

5. Please Describe Offense Briefly But Clearly.

_____

_____

_____

_____

6. How Did You Gain Knowledge Of The Offense?

_____

_____

7. Was The Offender Charged With the Offense? (Circle) Yes (Or) No

7a. If Yes, What Was The Charge?

_____

7b. If No, Why Not?

_____

_____

_____

9. Was The Offender Convicted Of The Offense? (Circle) Yes (Or) No

10. What Were The Age And Sex Of ~~The~~ Victim? ___ Years
(Circle) Male (Or) Female

10a. What Were The Age And Sex Of The Offender? ____ Years
Circle) Male (Or) Female

11. What Was The Relationship Of The Offender To The Victim? (For Example, Step-Brother, Stranger, Teacher, Parent, Personal Care Attendant)

_____

12. What Were The Nature And Extent Of The Victim's Disability (Or Disabilities)?

_____

12a. If The Offender Was Also Disabled What Was The Nature And Extent Of Disability?

_____

_____

13. In what way, If Any, Did The Victim's Disabilities Contribute To Vulnerability?

_____

_____

14.What Was The Nature And Extent Of Physical Injury To The Victim (If Any)?

_____

_____

15. What Was The Nature And Extent Of Social, Emotional, And/Or Behavioral Injury To The Victim (If Any)?

_____

_____

16. What Types Of Services Were Sought To Treat Or Support The Victim?

_____

17. If Treatment Or Support Services Were Sought, Was There Difficulty In Obtaining Services For The Victim Because Of the Victim's Disabilities?

(Circle) Yes (Or) No

18. If Services Were Sought, Did These Services Fully Meet Any Special Needs Of The Victim That Resulted From The Victim's Disabilities? (Circle One)

A. The Victim Received The Same Service As Others, No Special Services Were Required

B. Services For The Victim Met The Special Needs Of The Victim's Disabilities

C. Services Were Altered To Meet The Special Needs Of This Victim, But The Alterations Were Not Adequate

D. No Special Services Were Provided, But They Would Have Been Helpful

E. Special Services Were Provided Because Of The Victim's Disabilities, But Were Not Really Necessary

19. Did This Incident Occur In: (A) Canada (B) The United States (C) Other

20. Other Comments:

_____

_____

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